DOMESTIC HOMICIDE OVERVIEW REPORT

Report into the Death of David

Report produced by Peter Stride Independent Domestic Homicide Review Chair

Foundry Risk Management Consultancy

On behalf of Safer Somerset Partnership

Table of Contents

FOREWORD

The Safer Somerset Partnership would like to express their condolences to all those affected by the sad loss of David. We sincerely hope the learning and recommendations gained from our enquiries and deliberations will help agencies to prevent similar incidents from happening again in the future. As the Independent Chair of the Domestic Homicide Review Panel, I would like to thank all agencies who, contributed to the process in an open and transparent manner. This review has demonstrated that more needs to be done to raise awareness and change attitudes towards domestic abuse and that it is crucial to offer appropriate and timely help and advice to victims, their families and friends, and to professionals. I am confident the learning points and recommendations will provide a platform to help national, regional and local agencies to implement measures designed to prevent what happened to David from happening to others.

Following David's death, there is emerging evidence of positive change at a local level, and we all must do our utmost to take immediate action both to protect victims and to deal effectively with the circumstances and I would urge everyone to take note and act on the findings of this Review. Together we must take the threat and harm posed by domestic abuse seriously at a leadership, frontline and community level to help bring similar suicides to an end.

1. PREFACE

1.1 INTRODUCTION

1.1.1 This process has been completed under the Domestic Homicide Review framework and was commissioned under Sec 9(3) Domestic Violence Crime and Victims Act 2004.

1.1.2 This report of the DHR (hereafter 'the review') examines agency responses and support given to David, a resident in the county prior to the point of his death at home in September 2017.

1.1.3 In addition to agency involvement the review will also examine the past to identify any relevant background or incidents of domestic abuse, whether support was accessed within the community and whether there were any issues about accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.1.4 On the day of David's death police were called to the family home, by the South West Ambulance NHS Foundation Trust. David was found, by police officers to be lying in the living room having apparently taken his own life by suspending himself by the neck.

1.1.5 The review considered agencies contact/involvement with David and Tracey from 1st September 2012 until his death i.e. 5 years prior to his death. However, if any agencies had information, outside of this review period, that was relevant, then it has also been included in any chronology/IMR. This timeframe was agreed as being appropriate to capture all the relevant circumstances which reflected:

- The relationship between David and Tracey
- Significant milestones affecting his emotional state
- Their engagement with CSP agencies.

1.1.6 The key purpose for undertaking Domestic Homicide Reviews is to enable lessons to be learned from incidents similar to this, involving reports and concerns over domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each case, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.1.7 This review process does not take the place of the criminal or coroner's court proceedings nor does it take the form of a disciplinary process.

1.2 TIMESCALES

1.2.1 Safer Somerset Partnership (CSP), in accordance with the 'Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' (hereafter called the statutory guidance) commissioned this DHR. This was following discussions with the Home Office between 15th December 2017 and 16th July 2018, whereby the type and scope of review was discussed.

1.2.2 Peter Stride was commissioned to be the Independent Chair and Overview Report Author (hereafter 'the chair') for this DHR on the 25th September 2018. The completed report was passed to the CSP in December 2020. It was submitted by the CSP to the Home Office Quality Assurance Panel in December 2020.

1.2.3 Home Office guidance states that a review should be completed within six months of the initial decision to establish one. The timeframe for this review was considerably extended for a number of reasons:

- The chair was not appointed until September 2018
- The first panel meeting was not held until 5th November 2018 and subsequent meetings were held on the 6th February 2019, 9th May 2019 and 1st April 2020 to ensure agencies could attend and the questions and issues raised could be addressed
- To enable family contact and to allow this vulnerable group an extended period of grieving which lasted into 2020 before proper contact and engagement with the chair could be established.
- The chair has suffered personal grief with the passing of his father and additional recent significant illness within his family. This has necessitated the need for him to step away from professional matters for a period.

1.3 CONFIDENTIALITY

1.3.1 The findings of each review are confidential until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel. Information is available only to participating officers/professionals and their line managers.

1.3.2 In order to maintain anonymity, the various parties referred to in this review have been provided with alternative identities. The specific date of the death has been removed as has the gender of the children (to further protect the anonymity). Agencies who provided information to the review are, however, identified

1.3.3 The following pseudonyms have been used for the deceased, their partner (and other parties) as appropriate, in order to protect their identities. The ages of the children have also been omitted. These identities have been selected by the chair and agreed with the panel.

Name	Involvement	Ethnicity	Age (at the time of Death).
David	Deceased	Black	29yrs
Tracey	Partner	White British	27yrs
Child 2	Eldest child (of David and Tracey)	Dual Heritage	Blank
Child 3	Youngest child (of David and Tracey)	Dual Heritage	Blank
Child 1	Child of Tracey	White British	Blank
Jill	David's sister	Unknown	Unknown

1.3.4 Details of confidentiality, disclosure and dissemination were discussed and agreed, between panel members during the first panel meeting and all information discussed was treated as confidential and not disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

1.3.5 Agency representatives were personally responsible for the safe keeping of all documentation that they possessed in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

1.3.6 It was recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or gcsx. Confidential information was not to be sent through any other email system. Documents may be password protected.

1.4 TERMS OF REFERENCE

1.4.1 The full Terms of Reference are included in Appendix 1. The chair of the Safer Somerset Partnership has commissioned this review, following notification of the death of David in the county by Somerset Partnership NHS Foundation Trust. The review aims to

- Identify the learning from this death
- For action to be taken in response to that learning, with a view to prevent similar circumstances occurring again in the future
- Ensuring that individuals and families are supported.

1.4.2 The Review Panel comprised of agencies from Safer Somerset, as the deceased and family were living in that area at the time of the death. Agencies were contacted as soon as possible after the review was established to inform them of their need to participate and the need to secure their records.

1.4.3 *Key Lines of Inquiry:* The Review Panel considered both the 'generic issues' as set out in the statutory guidance and case specific issues i.e.

o Set out the facts of their involvement with David, Tracey and their three children.

o Critically analyse the service they provided to Tracey, David and Family in line with the specific terms of reference.

o Identify any recommendations for practice or policy in relation to their agency

o Consider issues of agency activity in other areas and review the impact in this specific case.

1.4.4 At the first meeting, the Review Panel shared brief information obtained from a 'summary of engagement' exercise about agency contact with the individuals involved. At this early stage it was clear that there had been a variety of contacts with agencies since the family moved from the Midlands in 2012. As a result, the panel agreed that a review period, beginning from when they moved to Somerset was most appropriate.

1.5 METHODOLOGY

1.5.1 The review has been conducted in accordance with statutory guidance under s.9 (3) Domestic Violence, Crime and Victims Act (2004) and the expectation of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016.

1.5.2 Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence'. The report uses the cross-government definition of domestic violence and abuse as issued in March 2013 and is included here to assist the reader, to understand that domestic violence is not only physical violence but a wide range of abusive and controlling behaviours. The definition states that:

1.5.3 Domestic Violence/Abuse is: Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.

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

1.5.5 Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

1.5.6 This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

1.5.7 This review has followed the statutory guidance. On notification of the death, agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) and chronologies from all the organisations and agencies that had contact with David, Tracey and the family. A total of 17 agencies were contacted to check for involvement. 9 agencies returned a nil-contact. 8 agencies submitted IMRs and chronologies. The chronologies were combined, and a narrative record was developed.

1.5.8 *Independence and Quality of IMRs:* The IMRs were written by authors independent of case management or delivery of the service concerned. The IMRs received were comprehensive and enabled the panel to analyse the contact with David, Tracey and their children and to produce the learning for this review. Where necessary further questions were sent to agencies and responses were received. Six IMRs made recommendations of their own and several evidenced that action had already been taken on these (See Appendix 2). The IMRs have informed the recommendations in this report. They have helpfully identified changes in practice and policies over time, and highlighted areas for improvement not necessarily linked to the Terms of Reference for this review.

1.5.9 *Documents Reviewed:* In addition to the eight IMRs, documents reviewed during the review process have included: a published account of the Coroner's summing up and letter written to the inquest by David's father. Further local policy documents were also read and considered:

- The guidance for safeguarding adults.
- The Somerset Domestic Abuse strategy.
- The local Positive Mental Health Strategy and toolkit.
- The Somerset 'One Team' toolkit for multi-agency meetings.
- The practitioners guide to MARAC
- The SIDAS guidelines for case management
- The Somerset Partnership Guidance document on Professional Curiosity.

1.6 Involvement of family Friends, work colleagues, neighbours and the wider community

1.6.1 The chair consulted with the police's Family Liaison Officers and sought guidance with regards to family contact. It appears that David and Tracey, had recently split up and there had been a good deal of hostility and acrimony, including with his sister Jill. David's parents live in the Midlands and their feelings towards Tracey are unknown. The chair discussed the situation with the panel, and it was felt that the volatile relationship between David, Tracey and Jill meant that direct contact, from a panel, to Tracey and Jill would create the impression that the matter was subject to an 'investigation' seeking to find blame and fault by immediate family members. The panel was concerned that such an impression may cause tensions to rise and risks to be increased.

1.6.2 The chair identified details of David's parents and on the 6th May 2019 a letter was drafted and sent to them, inviting contact and engagement with the review and panel. An offer was made to provide details of the Advocacy After Fatal Domestic Abuse, service. As this incident was not regarded as a domestic homicide the support of the National Homicide Support Service was not appropriate. There was no response to this correspondence. In an effort to further engage with David's family, the chair wrote a second letter to David's father in April 2020, making a similar offer of support and requesting engagement. As there was no response to this letter, we have therefore been unable to engage family participation in this review.

1.6.3 The chair made efforts to identify friends and work colleagues through the panel members however details have not been available for any employer or friends. The nature of the police investigation, as an unexplained death and not a homicide, meant that the breadth and depth of their enquires was less than during a homicide investigation and so no witnesses to the death or with knowledge of the family history were identified. The chair reviewed IMR's and chronologies and spoke with individual agencies, to identify any potential lines of enquiry, relevant to this subject, however these were unsuccessful also.

1.7 Contributors to the Review

1.7.1 A range of local statutory and voluntary sector agencies were contacted upon notification of David's death, to determine what, if any involvement they had had with the David, Tracey and any other relevant parties. The following agencies advised they had no recorded involvement with the deceased or the family.

- Adult Social Care
- South Somerset District Council

- The Multi Agency Public Protection Arrangement panel (MAPPA)/National Probation Service
- Community Rehabilitation Company
- Somerset Drug and Alcohol Service
- Taunton Deane Borough Council
- Victim Support
- Mendip District Council
- Somerset & Avon Rape and Sexual Abuse Support (SARSAS) service[1]

1.7.2 Individual Management Reviews and Chronologies were requested from the following agencies, all of whom were invited to form the panel.

Agency	Contribution
Somerset Partnership NHS Foundation Trust	Chronology and IMR
Avon and Somerset Constabulary	Chronology and IMR
Sedgemoor District Council	Chronology and IMR
Taunton and Somerset NHS Foundation Trust	Chronology and IMR
Children's Social Care	Chronology and IMR
Somerset Independent Domestic Abuse Service – Livewest	Chronology and IMR
The GP practice facilitated by Somerset CCG	Chronology and IMR
South Western Ambulance Service NHS Foundation Trust	Chronology and IMR

1.7.3 Each of the chronologies and IMR's were prepared by an author who was independent of matter. They had no direct line management responsibilities or involvement with the individuals subject to the DHR.

1.7.4 The chair has also sought the support of the local education authority. However, information regarding reported incidents, subsequent investigations and activities and onward referrals were not available to this review.

1.8 The Review Panel

1.8.1 The review panel consisted of:

Name	Role	Agency
Peter Stride	Chair	Independent Chair and Overview Report Author
Mark Wolski	Co-Chair	Co-Chair
Julia Burrows	Associate Director	Somerset Partnership & Taunton and Somerset NHS Foundation Trust
Heather Sparks	Named Professional Safeguarding Adults	Somerset NHS Foundation Trusts
Dr Andrew Tresidder	GP Patient Safety Lead	Somerset Clinical Commissioning Group

[1] https://www.sarsas.org.uk/

Charlotte Brown	Designated Nurse for safeguarding Adults	Somerset Clinical Commissioning Group
Roger Fawsett	Police Sergeant	Avon and Somerset Constabulary
Dave Baxter	Strategic Housing Manager	Sedgemoor District Council
Emma Martin	Team Leader	Children's Social Care
Leanne Tasker	Team Leader	Somerset Integrated Domestic Abuse Service
Suzanne Harris	Senior Commissioning Officer Somerset County Council	Somerset County Council (Safer Somerset Partnership)

1.8.2 Each panel member confirmed their independence from any previous involvement with any of the parties in this review, prior to the commencement of the review.

1.8.3 The review panel met four times on the dates above and on the final two occasions reviewed the draft report provided by the chair/author. Subsequently feedback was provided to the chair who signed off the report, electronically, in December 2020.

1.9 AUTHOR AND INDEPENDENT CHAIR

1.9.1 Independent Chair and Overview Report Author – Peter Stride

In September 2018 Peter Stride was appointed the chair and author of this DHR along with Mark Wolski who is the co-chair. Peter is a former Senior Detective in the Metropolitan Police, with 30 years operational service. He policed mainly within the arena of public safety, including Domestic Abuse and Child Sexual exploitation. Whilst working in the Metropolitan Police he was responsible for securing the first three DVPO's, in London and this success typified their passion and enthusiasm for supporting Domestic Abuse victims.

Since retirement Peter Stride along with Mark Wolski (below) have established their own consultancy business which focuses upon chairing Domestic Homicide Reviews and Serious Case Reviews for Community Safety Partnerships across the country as well as training and mentoring those in the public safety arena.

1.9.2 Co- Chair – Mark Wolski

Mark Wolski was appointed by Safer Somerset Partnership as Independent Co-Chair of the DHR Panel. He is a former Metropolitan police officer with 30 years operational service, retiring in February 2016. He served mainly as a uniformed officer, holding the role as Deputy Borough Commander across several London boroughs.

During his service he gained significant experience leading the response to Domestic Abuse, Public Protection and Safeguarding. Mark has subsequently acted as a consultant in the field of Community Safety, Independent Chair of a MARAC Steering Group and as a DHR chair/co-chair.

1.9.3 Peter and Mark have both completed Home Office approved training and received subsequent training by Advocacy After Fatal Domestic Abuse.

1.9.4 Neither Peter nor Mark have any connection with Safer Somerset Partnership or any of the agencies involved in this review.

1.10 Parallel Reviews

1.10.1 Coroner: The inquest was opened in September 2017 and the hearing took place in February 2018. The conclusion drawn by the coroner was that the deceased deliberately suspended himself by the neck, but his intentions at that time were not determined.

1.10.2 There were no other reviews conducted contemporaneously that impacted upon this review.

1.11 Equality and Diversity

1.11.1 The chair of the review and the review panel considered whether the protected characteristics of age, disability, gender realignment, marriage and civil partnership, pregnancy and maternity, race, religion (or belief) and sex, wherever relevant to this report.

1.11.2 In identifying the relevant equality and diversity issues for David the review panel noted that, David was a heterosexual male aged 29 at the time of his death. He was a British, black male who had been in a relationship with Tracey for 9 years. His religion was unknown, and he had no known or diagnosis of any disability.

1.11.3 The panel found no concerns over barriers to reporting and accessing services, in this case. Each agency also considered the wider issue of whether any service delivery was impacted by these characteristics, the conclusion drawn by each was that, with one exception this was not the case.

1.11.4 Due to domestic abuse consisting predominantly of violence by men towards women gender was a relevant protected characteristic.

1.11.5 The review panel considered the fact that in this relationship, where domestic abuse had been an issue, it was the male partner who had ultimately died and therefore was the subject of this review.

1.11.6 Analysis from the Office of National Statistics[2] record that in 74% of Domestic Homicides the victim were women and therefore a quarter (26%) were men. Also, that 7.5% of women are victims of Domestic Abuse as against 3.8% of men.

1.11.7 Issues of equality and diversity are referred to in this report. However, this was raised to individual agencies and the collective as part of the review process, and the panel felt that this was not an issue of concern with regards to services available or provided.

1.11.8 The panel considered whether or not their agencies recognised that 1 in 4 (as per paragraph 1.11.6) victims of domestic abuse were men and whether front line practitioners were aware of this, and whether they were suitably trained and experienced. Panel agencies have reviewed their own policies,

[2] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2019

procedures and training to confirm that, indeed, when dealing with cases of domestic abuse it is recognised that men can be victims as well as women.

1.12 DISSEMINATION

1.12.1 Once agreed by the Review Panel, the Executive Summary and Overview Report was be presented to the CSP for approval. After signing off they will be sent to the Home Office for quality assurance.

1.12.2 The recommendations are owned by CSP, and they are responsible for disseminating learning through professional networks locally, Progress and actions will be overseen and reported to the Somerset Domestic Abuse Board, on behalf of the Community Safety Partnership.

1.12.3 In addition to the agencies listed as contributing to the review, the report will also be disseminated to:

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

1.12.4 The report will be published online at www.somersetsurvivors.org.uk (the local Somerset domestic abuse website).

1.13 PREVIOUS RECOMMENDATIONS

1.13.1 Safer Somerset Community Safety Partnership have had 24 previous DHR's and the chair has requested details of relevant learning from those reports.

1.13.2 From these reviews previous learning has been identified and progress is recorded below.

- Avon and Somerset Constabulary should work with its partners within the Community Safety Partnership and Bristol Safeguarding Children Board to review the effectiveness of its Domestic Abuse Risk Assessment model and investigative practice regarding non-intimate partner abuse.

- Avon and Somerset Constabulary should take further steps to raise awareness of male victims of DA and also make officers aware of their own possible unconscious biases in circumstances involving male victims. The Force should also undertake checking and testing to see whether male victims of DA are currently receiving expected standards of service by the Force. This is also being led by the theme lead for DA.

2. BACKGROUND INFORMATION - THE FACTS

2.1 THE DEATH OF DAVID

2.1.1 David, Tracey and the children had lived in Somerset since 2012.

2.1.2 In September 2017 police were called to the family home of Tracey and David, following a report that there had been an 'Unexplained Death'. Upon arrival they met South West Ambulance staff, who had initially been called by Tracey. It was apparent that a belt had been attached to the banister of the stairs and David had hung himself. There were clear marks to his neck which were consistent with a ligature having been applied.

2.1.3 A Post-mortem took place two days after David's death and the pathologist recorded that there were ligature marks around his neck. The cause of death was recorded as 'Hanging'. An inquest was opened shortly after the death was discovered and the hearing took place in February 2018.. The conclusion recorded by the coroner was that "the deceased had suspended himself by the neck but his intention at the time was not determined".

2.1.4 Tracey and David's relationship had begun before they moved to Somerset and details of the family make up is recorded in paragraph 1.3.3. In the immediate period, before David's death, there were a number of factors which increased the pressure on him and Tracey, these are recorded within the combined chronology below. David and Tracey had been together for approximately 9 years; however, they had grown apart and as a result David had moved out of the family home, several months prior to his death to live with Jill.

2.1.5 At around 10am on the day of David's death, police were called to the family house by Jill. Officers attended and believed she was drunk and having a panic attack. No offences were disclosed, and no subsequent action taken. Later in the day Tracey contacted the GP surgery to express her anxiety about this matter and a second incident (later in the day) where she had called the police when David had reportedly damaged property at her address. The surgery made a referral to the Children's Social Care, who were engaging with the family as part of the Child and Family Assessment.

2.2 RELATIONSHIP HISTORY

2.2.1 The chair has made several efforts to contact David's parents without success and following the advice and guidance from the police Family Liaison Officers decided not to contact Tracey or Jill. This has made it difficult to collate background information and so the details provided here are based upon the details recorded in the review process.

2.2.2 David and Tracey had been in a relationship for approximately nine years. They lived in the Midlands until September 2012 when they moved to Somerset.

2.2.3 David worked as painter and decorator in the area and the couple had two children (Child 2 and Child 3), Tracey had a child from a previous relationship, Child 1, who also lived with them. The documented relationship between David and Tracey appeared to be volatile and he would appear to have struggled emotionally with his perceived pressures of parenting and financial responsibility within in this relationship. It appears to have manifested itself in several calls to the police by Tracey and a number of visits to the GP surgery by David. He would often discuss the stress and strain he was feeling particularly with regards to these expectations.

2.2.4 Until February 2017 the couple lived together along with their 3 children, when the couple separated, and David went to live with Jill. During their period of separation, the couple shared responsibility

for the upbringing and care of the children. Their relationship appears to have been emotionally difficult. Despite not living at the address David retained the joint tenancy (due to rent arrears), and so kept a key to the address and this appears to have often been a source of concern for Tracey. The volatility of their relationship led to regular calls to the police however very often circumstances were not as described once officers visited the address.

2.2.5. During the police investigation into this 'unexplained death' Tracey informed officers that she and David had reconciled, and he was due to be moving back into the family home, shortly before he died.

2.3 DAVID'S EMOTIONAL STATE

2.3.1 David has a recorded history of emotional and physical issues many of which could be described as stress related, he was a regular visitor to the GP surgery and the chronology of events records various incidents of interest:

- In May 2013 he visited the GP surgery to report having a seizure after allegedly being pushed down the stairs by his girlfriend.
- In January 2015 a tearful David visited the doctor. He was having trouble sleeping due to an upcoming criminal prosecution against him. Later in the month he returned to the surgery after the court case was adjourned. He told the doctor he was feeling depressed because of this.
- In March 2015 David visited the surgery complaining of being in a depressed mood as the court case was upcoming.
- In December 2016 David discussed his domestic circumstances and the stress he felt at home. He had collapsed in November and been taken to hospital.
- In January 2017 David collapsed at home and was taken to hospital.
- In June 2017 David spoke to the GP about the stressful circumstances in his relationship with Tracey and later in the month he again collapsed, at home. The attending ambulance crew had raised concerns about relationships within the home and a referral was made to the Children Social Care team.

2.3.2 This report raises this subject to give a flavour of the ongoing problems which David appears to be enduring. There are several other examples of David struggling to cope with both domestic and non-domestic problems. He was prescribed various medication and seems to be inconsistent in taking them.

3 COMBINED CHRONOLOGY

3.1 This section summarises information known to each agency that were identified as having had contact with David and Tracey in the 5 years prior to the death. Feedback was also requested from services, including those who had no record of meeting or engaging with them either as a family or as individuals. The agencies documented in section 1.7.2 returned completed chronologies and Individual Management Reviews (IMRs):

3.1.1 This chronology seeks to detail the history of the deceased and their family and seeks to record key events, contacts and involvement with them.

3.1.2 The chronology begins in September 2012 when the family moved to the Somerset area from the Midlands. There is little recorded history, prior to this review period, other than the GP Practice who report several contacts with David many relating to back pain although there is one matter of note regarding a laceration on his hand. Notes record that he fell on some glass however there is a report from an Emergency Department report in May 2011 from a hospital outside of Somerset, which states that he was assaulted with a glass bottle.

3.1.3 There are some references to referrals to 'education' services. Efforts have been made to engage with the local education authority however, contact has been minimal, and it appears that relevant information was not held.

3.2 2013

3.2.1 SOMPAR - The first contact with the family occurred on the **10th April 2013** when a health visitor attended their address to introduce the health visiting service. David and Tracey raised some concerns over the behaviour of their child and some historic domestic abuse issues. These were noted, however the couple reported that there had been no further domestic abuse issues since moving into the Safer Somerset area.

3.3 2014

3.3.1 POLICE - On **7th January 2014** Child 1 made a disclosure, at school, of being assaulted by Tracey. The police created an intelligence record and placed a warning flag on the file. There, was also a referral made to the Safeguarding Coordination Unit (SCU). And to Children Social Care (CSC), Health and Education.

3.3.2 SOMPAR - On the **7th of January 2014** the safeguarding children's nurse participated in a telephone conference following reports from Child 1 of being hit by Tracey (as above). As a result, the decision was taken for the school's nurse and health visitor to be informed and for the health visitor to arrange a visit.

3.3.3 CSC - On the **7th of January 2014** the CSC began Section 47[3] enquiries and as result a Children and Families assessment was completed in order to address the methods of discipline used by Tracey and the lack of warmth shown to Child 1. As a result a recommendation on the 25th of March for no further action to be taken. This was because David and Tracey denied the allegation made by Child 1. They also stated that they were willing to engage with Education and Healthcare services. The

[3] http://www.legislation.gov.uk/ukpga/1989/41/section/47

assessment also records that the three children were achieving expected outcomes in their development and therefore there was no further role for the CSC to play in these circumstances.

3.3.4 SOMPAR - During the health visitor appointment on the **23rd January 2014** Tracey disclosed that her brother had recently taken his own life and she felt as if she was still grieving for him. During subsequent liaison between the health visitor and children's social worker it was decided that a separate Child and Family Assessment was to be undertaken.

3.3.5 SOMPAR - Following the birth of their baby there were subsequent post-natal visits on **7th February 13th March** and **23rd April 2014**. No concerns were raised or noted.

3.3.6 POLICE - On **30th April 2014** David was prosecuted for assaulting a man, following a dispute. The victim sustained a broken jaw and David was charged with Grievous Bodily Harm.

3.3.7 Taunton and Somerset NHS Foundation Trust (TST) - **May – July 2014**. David was in contact with the TST Trauma and Orthopaedics department and treated for a fractured finger. David did not attend his final outpatient appointment. The IMR author documents that there was 'no reason to suspect domestic abuse'. No concerns were raised.

3.3.8 Sedgemoor District Council (SDC) - On **18th August 2014** David was spoken to and the issue of £700 rent arrears was discussed. It was at this time that he and Tracey were applying to move following the birth of their new baby. Due to these arrears the council were unable to proceed with this application, and a payment plan was put in place.

3.3.9 POLICE - On **21st August 2014** David made an allegation of racial abuse against a 3rd party. This appears to have been part of an ongoing dispute over a decorating contract, however there was insufficient evidence for a prosecution.

3.4 2015

3.4.1 GP - On **8th January 2015** David visited the GP Surgery and told the doctor that he felt depressed and that he couldn't sleep. He informed the doctor that he had been charged, by the police, with assault and that the trial date had been set for January 2015. David was asked about self-harming and he told the doctor that did have dark thoughts about cutting himself but as his partner (Tracey) had a brother who had taken his own life and that he couldn't put her through a similar experience. The doctor provided advice regarding support pathways including the Samaritans and the Crisis Team. The GP asked David to complete a PHQ9[4], prescribed a course of antidepressants and arranged to see David 7 days later.

3.4.2 GP - On **26th January 2015** David returned to the surgery with the PHQ9 which scored at 21[5]. He informed the doctor that his court case had been adjourned and that he felt as if things will never end. The IMR author records that David was very low and emotional, he continued to lose weight and struggled to sleep, and when he did sleep, he was having nightmares. David continued to have dark thoughts, but Tracey and the children were a protective factor. He agreed that he would access

[4] Patient Health Questionnaire - 9

[5] Depression Severity: 0-4 none, 5-9 mild, 10-14 moderate, 15-19 moderately severe, 20-27 severe.

'Talking Therapies'[6] and it was agreed that he would arrange a further appointment for two weeks later to check his progress.

3.4.3 SDC - On the **30th January 2015** It was confirmed that all rent arrears had been cleared.

3.4.4 SDC - On the **24th February 2015** a housing 'match' was placed on hold due to the upcoming court case. David confirmed that he had been charged with Grievous Bodily Harm and the matter had been adjourned. A letter sent from SHAL housing[7] (See section 4.9 below), to confirm the situation.

3.4.5 POLICE - On **6th March 2015** Child 2 was assaulted after having deodorant sprayed in the face, by a 'teenager'. Officers spoke to both parties and no further action was taken.

3.4.6 SDC - On the **19th May 2015** Rent arrears of £3067.49 had accrued and appeared to be increasing. SHAL housing decided to apply for repossession.

3.4.7 SDC - On the **3rd July 2015** a 'match' to move home was approved.

3.4.8 POLICE - On **17th November 2015** Tracey contacted the police and alleged that David had assaulted her, causing a bruise and swelling to her hand and arm. David was arrested after admitting the assault and told the officers that he had done this due to his frustration with Tracey. He was charged with the offence and sent to court where he was bailed and given various conditions including restricted contact with Tracey and the children, however Tracey contacted the police to complain about these conditions and that David wasn't a bad person and he hadn't, in fact, assaulted her. Referrals were made by the SCU. These referrals were sent to the Health and Education departments and CSC. Attempts were made by the Lighthouse team[8] to contact Tracey however they were unsuccessful. A DASH risk assessment was completed, with Tracey, and deemed to be standard risk. Ultimately Tracey withdrew her allegation, however as he had already admitted the offence he was convicted, with the court imposing a fine.

3.4.9 CSC - On **18th November 2015**. it was reported to the CSC that David threw a mobile phone at Tracey, consequently David was charged with assault and the court had imposed bail conditions preventing him from contacting the family other than through his solicitor (See entry above).

3.4.10 SOMPAR - A domestic abuse notification was received, by the health visitor, from the police on **26th November 2015**. They then made 5 attempts to contact Tracey including an unannounced visit to the house. Subsequently the health visitor was contacted (by the new occupants), and informed that Tracey no longer lived at the address. The health visitor identified a new address and attempted to make contact however they were also unsuccessful.

3.5 2016

[6] Somerset Partnership NHS Trust provide a service to patients with a variety of conditions

[7] http://www.shal.org/

[8] [8]***Lighthouse*** *is a team of staff from the police and victim support organisations, working together to guide, advise and support victims and witnesses.* https://www.lighthousevictimcare.org/

3.5.1 POLICE - On **10th July 2016** Tracey contacted the police and said she reported that Child 1 had been sexually assaulted and was viewing inappropriate material on the internet. Officers spoke to Tracey and confirmed that no offences had been committed but there were clear safeguarding concerns, these were rereferred to the Multi Agency Safeguarding Hub (MASH) (see 3.5.2 below).

3.5.2 Following the referral to the MASH and a discussion took place on the **21st July 2016**. It was decided that 'Education would take the lead'. At this meeting it was agreed that CSC would visit Child 1 at school and consider a Child Protection medical. The social worker was tasked to also ascertain how Child 1 was treated at home and to contact the midwife regarding pregnancy.

3.5.3 POLICE - On **6th December 2016** Tracey called 999 and alleged that she been assaulted by Jill. Both parties were interviewed with each person indicating that they had been the victim of an assault, by the other. Officers completed an investigation including witness interviews and local enquiries however the evidence that was gathered failed to reach threshold for prosecution and as a result no further action was taken. There was a safeguarding referral to CSC regarding the four children in the premises, Tracey's 3 children and Jill's child.

3.5.4 South West Ambulance Service Foundation Trust (SWASFT) – On **6 December 2016** called by the police to attend a family address. On arrival it was alleged that Tracey had been assaulted by Jill, by punching her in the face and pulling her hair. David was present at the time of the incident and had pulled Jill away from Tracey, Tracey had called the police. On arrived at the scene a request was made (by the police officers) for the assistance of an ambulance. Tracey had dried blood on the left ear and a swelling or contusion to left cheekbone and eyebrow. Tracey did not go to hospital but was advised to call 111 or 999 if any symptoms developed following this injury.

3.5.5 CSC – Following the incident the **6th December,** there was contact from Somerset Direct[9] to Tracey. Tracey confirmed that although all three children were present during the incident, they were largely unaffected. Tracey told Somerset Direct she would not allow Jill back in the home. But said she would not be pursuing criminal charges following advice from the police that there was not enough evidence to charge Jill. Tracey stated that this was an unprovoked attack "you cannot predict the actions of Jill", she agreed that if Jill contacted her again, she would call the police therefore no further action was taken by the CSC.

3.5.6 SWASFT – On the **27th December 2016** an ambulance was called to the family address. David was seen and reported as being under recent stress and become depressed. Tracey had witnessed him collapsing and he had become unresponsive for a few seconds, he'd hit his head and subsequently vomited. Upon arrival David was sat on the sofa and confirmed that there had been recent collapses and he'd had a CT scan at Weston-Super-Mare Hospital. He was advised to attend the emergency department at the hospital, which he agreed to do. David was very emotional, and the family were also concerned about the mental health. They requested that this be reviewed at the hospital.

3.5.7 GP - On **28th December 2016** David visited the surgery and informed the doctor of problems at home including financial and family. The doctor also noted a history of self-harming, and David was prescribed a course of anti-depressant tablets, provided with some reassurance and advised to re-attend in two weeks.

[9] Somerset Direct is the councils Customer Service telephone enquiries line.

3.6 2017

3.6.1 SWASFT – On **9 February 2017** David had returned from work at 6:30am and had pain in the centre of his chest. The pain was described as heavy and constant. David was also experiencing intermittent severe headaches. He was advised to attend the emergency department at hospital but declined, on several occasions, telling the ambulance crew that he had an appointment to see his GP the following morning. David declined to sign the refusal form.

3.6.2 POLICE - On **12th February 2017**, following reports of a woman shouting, police officers attended the home of David and Tracey. Officers spoke to both parties, who were there with their two children, and Tracey revealed that David was having mental health 'issues' and that he had been self-harming by attempting to cut his arms. Officers spoke to David who disclosed that he was struggling to cope with the expectations placed upon him by Tracey, including money worries, anxiety and general health issues. Officers observed some minor cuts to David's arms and confirmed that they were self-inflicted. David was also anxious that Tracey was having an affair with her ex-partner.

3.6.3 Whilst at the address officers ensured that David had contact with the Mental Health Triage nurse, who is employed at Avon and Somerset Police Headquarters. David expressed his desire to end his relationship with Tracey. He decided to go and stay with his mother and this was supported by Tracey. As there was no crime alleged or committed the matter was recorded as a 'Domestic Incident'. A DASH risk assessment was completed with Tracey and concluded that the risk presented by David was standard. The SCU made three referrals on the 13th of February to CSC, Health and Education.

3.6.4 CSC - On **15th February 2017**, following the 12th of February incident, Somerset Direct called the couple who denied that any such matters had occurred. An email was sent to the health visitor requesting a 'targeted visit; and to consider an Early Help Assessment[10]. This Assessment recommended a referral to the Somerset County Council 'Get Set' support service'. David and Tracey asked for time to consider this. Ultimately the referral was not made by the health visitor as consent was not provided by the family[11]. David decided to leave the family home and move to his mother's for some respite.

3.6.6 CSC - On **15th February 2017** the Council Tax offices received a call from Tracey stating that she could not afford to pay the bailiffs who had attended her home due to the outstanding debt. The bailiff's activities were put on hold until an income and expenditure form had been submitted to the local District Council. A refusal to engage with the bailiffs and the payment of outstanding rent arrears continued until David's death.

[10] An EHA Assessment is intended to capture the needs of children, young people and their families at the earliest opportunity. It is used by all agencies in Somerset.
http://professionalchoices.org.uk/eha/

[11] Tracey stated that she and David intended to stay together. David had seen the doctor and been sign posted to the 'Rights Steps service, which is provided by the NH, for those experiencing emotional and psychological distress. David had made this contact and was placed on their waiting list. A review by the panel has confirmed that an Early Help Assessment required consent from the couple and the Health Visitor was requested to ask for it. It appears that, if the request was made it was not given.

3.6.7 SWASFT – On **24 May 2017** an ambulance was called to David's workplace as he had been seen by a co-worker to collapse as he was walking across the concrete floor. David was seen to fall backwards hitting his head and lost consciousness for about a minute before making a spontaneous recovery. David stated there had been several episodes recently of chest pain. As a result of this he was taken to hospital where he was treated.

3.6.8 SDC – On **9th June 2017** SDC awarded a Discretionary Housing Payment of £1500 which reduced the rent arrears to £1916.[12]

3.6.9 SWASFT – On **26 June 2017** an ambulance was called to the family address. David had collapsed and been unresponsive for several minutes. On arrival he was sat on the sofa with Tracey and four children. He seemed stressed and unsettled but David refused to go to the hospital as he was concerned about the children. Tracey and David began to argue, and this upset the children. Jill arrived and spoke to the ambulance crew. She said that David had been stressed and that the children were running late to school most days.

3.6.10 David said the children were going to a party and he was going to take them with Jill. Tracey became quite aggressive and started shouting and calling everybody names. The ambulance crew called for the assistance of the police as there was concern for the welfare of the children. Ambulance staff raised concern, to the police, about Mum's presentation towards the children and how much more relaxed the children were when Mum left the room.

3.6.11 POLICE - On **26th June 2017** Police were contacted by the SWASFT (As per 3.6.9). At the time of the report, they were in attendance at the home of David and Tracey, and they had concerns over the welfare of the couple's children. Officers attended and discovered that David, who been treated for a panic attack, had left the address along with two children and gone to Jill's house, where they were now staying. The following day officers visited Jill and satisfied themselves that the children were fit and well. No DASH risk assessment was completed but officers evaluated the risk as 'standard'.

3.6.12 POLICE - On **27th June 2017** Tracey contacted police and complained that earlier in the day David had collected her from the children's nursery, and on the way home begun to shout and swear at her. Once at home this behaviour had continued, and he had thrown some of her clothes into the street. Tracey had called the police from her friend's house as she did not want to return home due to David's verbal abuse and self-harming habits. Police attended the addresses and spoke to both parties; they were advised to formalise their childcare arrangements in order to avoid future conflict. A DASH Risk Assessment was completed, with Tracey, and graded as medium.

3.6.13 CSC - On **28th June 2017** David telephoned Somerset Direct regarding Tracey's ability to care for their children, and an argument took place with between the two whilst on the call.

3.6.14 SDC - On the **29th of June 2017.** The housing officer interviewed David in relation to his shared tenancy with Tracey. David advised his relationship with Tracey had become difficult. He also alleged that Tracey was neglecting the children, and CSC were carrying out an investigation. He was told by the housing officer that if he gave up his part of the tenancy, it would threaten their shared tenancy

[12] A further payment of £1573 was paid by Sedgemoor District Council on 25/10/17 and £605.95 was paid by Sedgemoor District Council in Housing Benefit for the dates 11/9/17-26/10/17. The outstanding balance of £1733.99 was paid by Tracey on 3/11/17.

and family home. David was advised not to give up the tenancy until the outcome of the CSC investigation was known. The housing officer did not pursue this any further but advised David to wait for the results of this investigation as "this may have an effect on your relationship with Tracey", and subsequently upon their tenancy.

3.6.15 POLICE - On **29th June 2017** there were 3 calls to police, from Tracey, on each occasion following attendance at the address no criminal offences were disclosed. Officers provided Tracey with civil remedies advice to manage her relationship with David and to protect her home. The officers carried out enquires with neighbours who reported having no concerns. Aggravating factors, including mental health and drug use were recorded on police systems, and the matter was passed over to the local beat manager who spoke with Tracey the following day.

3.6.16 POLICE - On **3rd July 2017** Tracey contacted police and CSC to complain about David entering her home and making threats towards her and her friend. It was established that David remained on the tenancy despite their breakup. Tracey told the officers that David was selling drugs, that he had a long criminal record, and she did not feel safe. Tracey said the Housing Association had refused to take David off the tenancy due to outstanding rent arrears. Tracey was advised to seek refuge accommodation, but she responded by saying it was too dangerous to walk where he could see her. Arrangements were made to visit her on the 6th July 2017.

3.6.17 CSC - On **5th July 2017** Tracey reported, to CSC, that David had grabbed her hair and pulled her across the room. She did not wish to substantiate any allegations. At this point a Social Worker was appointed to work with the family.

3.6.18 POLICE - On **5th July 2017** there were several calls regarding an incident involving Tracey, David and two other adults, with neighbours hearing the sound of children crying. Subsequently there were calls from Tracey and one of the males who had been in the property. Police officers visited the address, found David outside and Tracey inside. There were no other adults present. David told officers he had concerns for his children and of Tracey's drug misuse. The officers went to the premises and spoke with Tracey who alleged that she had been assaulted by David. The dispute appeared to be about the care and custody of the children with both parties feeling that they were the most appropriate person to look after them. David was arrested for assaulting Tracey. During the police interview David disclosed that Tracey had attacked him by pushing and kicking him and then he pushed Tracey to get away from her. It was decided that there was insufficient evidence to pursue a criminal prosecution.

3.6.19 A DASH risk assessment was completed and graded high regarding the risk presented by David to Tracey. The officers were able to provide options for her safety, including for herself and her home. The officers spoke with a witness who confirmed that David did not assault Tracey. A SCU referral was made regarding a potential MARAC referral but the decision was made not to take this forward.

3.6.20 POLICE - On **6th July 2017** the prearranged visit with Tracey, following the complaints on the 3rd July, took place. They discovered that the locks on both front and back doors weren't working, officers contacted SHAL housing to report this. SHAL confirmed that any repairs would be chargeable, and that Tracey had not been engaging with them or the Department of Works and Pensions (DWP). Consequently, Traceys benefits had been stopped and there were significant rent arrears on the property, and this had meant the David could not be removed from the tenancy. Tracey was told that if the locks on the doors were changed then David would have to be given a set of keys as he

remained on the tenancy. Information was given to Tracey about the refuge option however she told officers that if David came to the refuge, she would let him in, therefore the refuge was not a viable option.

3.6.21 Officers completed a BRAG (Blue Red Amber Green) risk assessment[13], regarding the welfare of the children, with Tracey. They noted that the property appeared to be well kept and that Tracey was cooking a meal for the family, whilst they were there. The police officer spoke to Tracey about her children and the reasons for making a safeguarding referral. She understood the concerns about the children hearing and witnessing violence. Whilst at the premises the officers formed the view the Tracey had been using drugs prior to their arrival, this was based on Tracey's presentation rather than any clear evidence. The officers completed a DASH risk assessment, the outcome of which was to classify her situation as 'high risk'. They provided support and advice regarding housing and made a referral to the SCU, specifically the CSC, education and health departments.

3.6.22 (SIDAS) Livewest - On the **11th of July 2017** a referral was received from 'Lighthouse' following reports of a disturbance, involving several adults at the family home of David and Tracey (As per the entry 3.6.18). A case worker was allocated and efforts to contact Tracey were made, by calling the home telephone number, this proved unsuccessful and further calls were made over the next 10 days.

3.6.23 SDC - On **17th July 2017** David attended the SHAL housing offices and offered to pay half of the outstanding rent arrears and a further £400 a month until the remainder was cleared. He was due to start a new job the following day.

3.6.24 POLICE - On **19th July 2017** Tracey called 999 to complain that David had let himself into the property and refused to leave, however by the time Tracey had called, he had left. No crimes were alleged, and she was given advice regarding civil remedies and the matter were recorded as a domestic incident and closed.

3.6.25 (SIDAS) Livewest - On the **21st July 2017** the caseworker contacted the Lighthouse Victim and Witness Care Programme (LSU) and was provided with Tracey's mobile phone number. The caseworker called this number and spoke to Tracey. She confirmed that her relationship with David had ended and he had moved out of the family home. She also informed the caseworker that CSC were not involved with the family and she felt safe at home. She declined any further support and was provided with the SIDAS contact number and reassurance that she could seek assistance in the future.

3.6.26 SDC - On **31st July 2017** David visited the offices reception and informed staff of the breakdown of his relationship with Tracey. He told staff that he felt he couldn't return to the property. An appointment was made for him to meet the housing officer on the 4th August.

3.6.27 CSC - On **3rd August 2017** Tracey reported, to the CSC, that she had a verbal argument with David, and he wouldn't answer her questions or leave the property. There was no evidence that either parents or the children were spoken to by social worker.

[13] This tool is to support officers in identifying and describing the vulnerabilities at an early stage it helps officers put themselves in the shoes of the vulnerable person and understand their experiences as they see it. https://www.avonandsomerset.police.uk/foi-request/167745-support-for-victims-of-crime

3.6.28 POLICE – David was stopped and searched, along with four other males following intelligence suggesting they had been smoking cannabis in a pub garden. No crime was identified, and no further action was taken.

3.6.29 SWASFT – On **16 August 2017** an ambulance was called to the family home, upon arrival David was upstairs. Tracey said he would walk down to greet the crew but did not want to go into the ambulance for assessment due to the neighbours. David was examined and told the ambulance crew he had experienced blackouts and had had intermittent stabbing pains in his chest. He also told the ambulance crew he wanted his family back and that only he can help himself. David refused hospital attendance for further assessment and did not want the crew to refer things to his own GP. He was advised to contact the GP or call 999 again if the pain returned.

3.6.30 SDC - On the **17th August 2017** a call was received from SHAL housing. They confirmed that a suspended possession order on the family had not been adhered to and that Tracey was not engaging and SHAL, who would be applying for an eviction notice.

3.6.31 CSC- On the **25th of August 2017** the social worker completed a home visit with David and Tracey. Tracey informed the social worker that she felt things are much better now and that she and David had resumed their relationship. She informed the social worker that he's not living at home at the moment, and they are taking things slowly. Tracey felt she that she did not require support in meeting the childrens needs as they are all now 'living under one roof'.

3.6.32 SDC - On **4th September 2017** a warrant of eviction was confirmed, and an eviction date set for the 27th September. David and Tracey were advised to seek legal advice.

3.6.33 SDC - On **6th September 2017** Notification was sent to David and Tracey, from SHAL, with regards to the issuing of a warrant of repossession. David also failed to attend an appointment at the office.

3.6.34 POLICE - At 5:14am the day before David's death in **September 2017** Jill called the police to inform them that she's returned home, after a night out at the cinema, with David, and he had tried to bite her. Officer visited the address, following reports from neighbours, of a female screaming and shouting. They discovered Jill, who appeared to be drunk and having a panic attack. The officers managed the immediate situation and established that there was no on-going risk and before leaving the address.

3.6.35 Later, at 10:21am Tracey called the police to report a disturbance, caused by David, inside the house. Officers used Body Worn Cameras to record events as they arrived but discovered there to be no injury to any party's nor significant damage. A DASH risk assessment was completed with Tracey and the grading was standard. She told officers that there was no domestic abuse in their relationship, but she was worried about him self-harming. She told officers that he had tried to stab himself and that this purely an act of frustration. She had no concerns for herself or the children.

3.6.36 David was extremely upset and collapsed in the kitchen; this was believed to be due to an on-going heart condition. An ambulance was called and whilst waiting David regained consciousness, he explained that he was struggling to meet the expectations of others, was disappointed at the breakdown of his relationship with Jill and spoke of feeling very stressed. Tracey's presence appeared to raise David's anxiety levels and she agreed to leave the house. David discussed the incident

(5:14am, 3.6.34 above) and confirmed that Jill had assaulted him, showing them various injuries including a bite mark to his face. The officers then called Jill to discuss the incident she stated no offence had been committed and she had not been assaulted. The officers arranged to go and see Jill to complete a DASH risk assessment.

3.6.37 Following the assessment officers concluded that no offences had been committed and in order to prevent further call outs David was advised not to go to the address and to go and stay with friends following his release from hospital. David was very tearful and upset and accepted that he needed some mental health assistance, the paramedics were briefed and agreed that the information should be shared with the ED staff. Upon his arrival at hospital the officers confirmed that the three children were safe and well and not distressed as they were not present during the original incident.

3.6.38 The ambulance assessed David's condition; his heart appeared to be stable however there was concern about the bite to his face. Consequently, he was transported to Musgrove hospital.

3.6.39 SWASFT – with regards to the incident above (3.6.36) the ambulance crew was called by the police and arrived at 12:25 pm. David had been involved in two incidents both involving domestic abuse. The ambulance crew notes suggest that he had been bitten three times, once on the lip and twice on the hand. The second incident involved Tracey, and had necessitated a police investigation. In the presence of the police David collapsed, prior to that he grabbed a knife and threatened to stab himself. Although injuries to this thumb and on his lip were minor the skin had been broken, and it was apparent David was having a mental health crisis, he also disclosed issues of alcohol abuse and drug misuse. As a result, David was taken from the address to hospital.

3.6.40 TST/SOMPAR - the day before David's death in **September 2017** David attended the TST Emergency Department as a result of two incidents. The first matter related to him being bitten on the lip and hand by Jill, this matter was attended by the police (see 3.6.33). The second incident related to an argument with Tracey where he threatened to stab himself. Records reflect that police were involved and advised David to attend the hospital. He collapsed whilst with the ambulance crew and in the Emergency Department he told staff that he was pushed downstairs and had pain on the right hand-side of his face and a headache. David smelt of alcohol and stated that he had been drunk the previous night and used cannabis. He had a CT head scan and blood tests and his mother confirmed that he was not involved with any Mental Health Team, however there was concern for his mental health. He was referred to the Psychiatric Liaison Team (PLT) for an assessment, to be carried out whilst he was still in ED. However due to the volume of referrals, that afternoon they were unable to see David immediately. When the PLT team did attend the A&E Department David had left the hospital. There was no subsequent follow up either at home or via a phone call.

3.6.41 SOMPAR - There was a further report on the day before David's death in **September 2017** where Tracey was the alleged perpetrator of domestic abuse towards David. Concerns were also raised regarding his mental health; therefore, he had been taken to A&E.

3.6.42 CSC - The CSC received a referral on the day before David's death in **September 2017** that Tracey and David had argued, and David had become upset pushing over wardrobe however no damage was caused.

3.6.43 POLICE – In **September 2017** officers attended the home address of David and Tracey following a call from SWASFT. David had taken his own life and been found by Tracey. He was pronounced dead at the scene, despite SWASFT staff making every effort to revive him.

3.6.44 Tracey told the officers David was at the address at the time she was bathing one of the children in the downstairs bathroom next to the kitchen. David was in the kitchen smoking and she heard him shout "bye" and thought he had gone out, when she left the bathroom, she went to get some bed clothes for the child and as she walked upstairs, she found him hung with a fabric belt from a coat tied to the handrail, he was unresponsive and cold.

3.6.45 Forensic medical examiners attended the address, and the ligature was seized, but no suspicious circumstances were found therefore the matter was handed over to the coroner's officer.

3.6.46 A referral was made, by the police, to the CSC.

3.6.47 In line with force procedure this matter was reviewed by the IOPC[14], due to the recent contact between the parties and the police. On behalf of the IOPC the Avon and Somerset Constabulary Professional Standards Department reviewed the case and the circumstances of police engagement with the family. This review was concluded determining that there was no link between David's death and police contact.

4 Overview

This section summarises information known to each agency who were identified as having contact with David and Tracey in the 5 years prior to the death.

The chair has sought the support of the local education authority. However, information regarding reported incidents, subsequent investigations, activities and onward referrals were not available to this review.

4.1 Avon and Somerset Constabulary.

The IMR prepared by the police was compiled from information contained within police intelligence data bases, criminal records and the viewing of Body Worn Video cameras (BWV). The review confirms that during the period of the review there were a total of 20 separate police contacts relating to David and/or Tracey. The IMR author has separated them into 3 categories I.e.

- 9 non-violent domestic incidents
- 4 domestic incidents involving physical violence (2 concerning Jill).
- 7 related to other matters.

4.1.1 David's death was investigated by police officers and crime scene investigators, and several items were recovered from the scene. However, as no third parties appeared to have been involved, it was not considered suspicious, and the matter was 'filed'.

[14] https://www.policeconduct.gov.uk/

4.1.2 The IMR author has considered each of the 20 police contacts and prepared a summary of each incident, the action that was carried out and analysis of officer's performance. They have recognised that there are two opportunities to improve performance both of these have been referenced and refer to previous DHR recommendations. The IMR are also identifies areas of good practise and these are highlighted in the analysis section.

4.2 Children's Social Care – CSC

4.2.1 The IMR author documents that the family moved to Somerset in 2012 and following an interview with CSC staff, it was confirmed that there had been previous domestic incidents outside of the county. Some of which had been witnessed by the children, although they themselves had never been assaulted or injured.

4.2.2 The IMR author reviewed the case notes, supervision and assessments, however, was unable to speak to the 'allocated' social worker, who worked with the family, as they have now left the authority.

4.2.3 The IMR confirmed that there were 15 contacts with the family between 7th January 2014 and 12th September 2017. The family had been resident in Somerset for 16 months prior to the initial contact which was on 7th January 2014 and related to a disclosure at school, by Child 1, of being physically chastised by Tracey. Child 1 indicated that it had happened more than once, which left red marks on Child 1's body. The school contacted CSC and following enquiries under Section 47 of the Children's Act 1989 a Children and Family (C&F) assessment, concluded that no further action was required. This was because the parents had denied the allegation and agreed to engage with the education and health authorities.

4.2.4 It was not until 18th November 2015 that any incident of Domestic Abuse came to the attention of the CSC, three years after the family had moved to the area and almost 2 years after the initial report by Child 1.

4.2.5 There were 7 contacts between 15th April 2015 and 28th June 2017. No subsequent action was taken as a result of these incidents other than on one occasion when the outcome of the C&F assessment was made after the death of David.

4.2.6 There were 7 further contacts between 3rd July 2017 and 12th September 2017. The IMR author reports that 6 of these reports related to Domestic Abuse, with police involvement.

4.3 Taunton and Somerset NHS Foundation Trust – TST

4.3.1 The IMR author's report confirms 4 contacts with David and/or Tracey between 1st September 2012 and David's death, only one of these incidents was linked to domestic abuse. There were 4 further contacts involving the couples 3 children, none related to domestic abuse and therefore will not be detailed in this review.

4.3.2 Staff were not interviewed during the preparation of the IMR due to the brevity of contact and the time elapsed since the contact was had.

4.3.3 There was no evidence, provided to the TST Emergency Department that David was considered to be a victim of Domestic Abuse. In September 2017 there were two incidents, one involving David and Jill and then his partner. The first instance was an allegation that Jill had bitten him on the lip and twice on his hand, and in the second incident David had argued with Tracey and he had threatened to stab himself. The records indicate the police had been involved and advised David to attend the Emergency Department. He then collapsed when with the ambulance crew and on arrival at the Emergency Department he told staff that had been pushed down the stairs and had pain on the right-hand side of his face and on the left-hand side of his head. He had smelt of alcohol and says he was drunk last night and used some cannabis. He had a CT scan and blood tests and his mother told ED staff he was not involved with any mental health team. There was a plan for mental health review by the PLT however he was unlikely to wait and he's been picked up by some friends.

4.4 Sedgemoor District Council Housing Health and Well Being

4.4.1 SHAL housing is a community-based provider of social housing. They have over 700 properties in Somerset and offer affordable accommodation for the homeless or are in housing need. Housing is provided to potential tenants through the Homefinder system as part of a countrywide lettings process. SHAL employ 19 members of staff who have all received Safeguarding and Domestic Abuse/Violence Training.

4.4.2 The author has prepared their review for the purpose of assessing the effectiveness of Sedgemoor District Councils response to its contact with David and Tracey. Research was completed using the 'Homefinder Somerset' and 'SHAL Housing' databases, for benefit claims and revenue as well as various paper records. The author completed one to one interviews with associated department representatives.

4.4.3 Their research confirmed that SHAL Housing were the accommodation provider, for David and Tracey, during the period of this review.

4.4.4 During the period of review there were 7 contacts between Sedgemoor District Council and the couple, between 5th October 2013 and the days shortly before David's death. None have been interpreted as relating to domestic abuse issues.

4.4.5 The chair has reviewed the chronology supplied by the author and many entries refer to general housing issues and processes including registration, tax credit, income support etc. There are several entries that relate to non-domestic abuse risk management issues and this report will not detail their content.

4.4.6 The family were initially receiving Housing Benefit, which transitioned to Universal Credit following David's employment and then sickness. The scheme was very new and there were teething problems. In addition, under Universal Credit processes, rent payment was sent directly to the tenant rather than in Housing Benefit which is paid directly to the landlord. At the time there was also a built in 5-week delay and the first week of the claim was not paid. This has changed since, although the 5 weeks delay still stands. In the months prior to David's death the family received £1,500 to safeguard them until rent arrears were paid off and, subsequent to David's passing, Tracey received a similar payment. Details of these matters are recorded in point 3.6.8 and associated footnote.

4.4.7 Throughout the various financial and housing problems that the family suffered, SDC and SHAL housing spent a good deal of time working with David and Tracey including in matters of rent arrears (as demonstrated above), property repairs, and supporting them through the court processes when, eventually eviction proceedings began.

4.5 Somerset Clinical Commissioning Group (CCG).

4.5.1 In order to complete this review, the CCG author has reviewed the GP Practice Health Records and completed a full review of David GP records. Between the 9th September 2010 and David's death there were a total of 28 contacts between David and the GP Surgery. A number of these contacts were about his mental well-being for which he was prescribed medication. The IMR author records that there was one contact in 2013 that might have prompted an enquiry about Domestic Abuse when he presented at the surgery but no others since 2013.

4.5.2 A summary of the contacts is recorded in the chronology as well as reports of depression and its treatment. (The chair believes that the periods of depression were linked to an impending prosecution which David was facing, however David also mentions, when visiting the GP surgery, problems at home and with finances).

4.5.3 The IMR author comments that during each attendance at the surgery GP's demonstrated good practice in primary care, including the completion of the PHQ9 proforma, resultant referral to support agencies and prescribed medication.

4.6 Somerset Partnership NHS Foundation Trust (SOMPAR).

4.6.1 The IMR author has prepared a chronology and IMR report which details contact with both the deceased and partner during the review period. Research was conducted using the internal Patient Record systems. Staff from the Psychiatric Liaison Team were interviewed in 2017 as part of the 'Sompar Level 1 Concise Investigation Report'.

4.6.2 The initial contact came in April 2013 when the Health Visitor visited the family to introduce available services. David and Tracey had been living in the area for seven months when they reported some concerns regarding Child 1's behaviour plus historical domestic abuse.

4.6.3 There was further involvement, in January 2014, following a report that Tracey had hit Child 1 and later in the month, during an ante natal visit, Tracey disclosed that her brother had taken his own life. As a result of the allegations, made about Tracey's methods of disciplining Child 1, and the perceived lack of warmth, between mother and children, there was a discussion with the CSC, it was agreed that a Child and Family Assessment should be undertaken.

4.6.4 There were several visits following the birth of Child 3, no issues were raised.

4.6.5 Following a domestic abuse notification in November 2015 by the police, several attempts were made to contact Tracey, however it became apparent that she no longer lived at the address held on the agency's records.

4.6.6 There were no further contacts with either David or Tracey until July 2017 when 3 separate domestic abuse notifications were received, a progress note from the Mental Health Triage team and a receipt

from the (SWASFT) following their attendance at the family home after a report that David had been self-harming.

4.6.7 The IMR author comments that there was one meeting with Tracey, by the health visitor, in August 2017 and that this was the first visit since 2015. There were no subsequent visits until after the death of David.

4.6.8 There was a further report in September 2017 where Tracey was the alleged perpetrator of domestic abuse on David. Concerns were also raised regarding his mental health following his attendance at the ED department of Musgrove hospital and referred to the Psychiatric Liaison Team (PLT).

4.7 Somerset Integrated Domestic Abuse Service (SIDAS) – Livewest

4.7.1 The IMR author has completed their report having viewed case notes and the internal records database. There was only one contact with either David or Tracey, however a number of efforts were made to contact Tracey, following a referral by the Police Lighthouse Victim and Witness Care Programme (LSU), on the 11th July 2017, following the report of several people causing a disturbance in the home. These efforts were unsuccessful.

4.7.2 On the 21st July 2017 the case worker contacted the Lighthouse Safeguarding Unit who confirmed that Tracey had a new mobile phone number. This number was called, and she confirmed that she had ended her relationship with David, and he was currently staying with Jill. Tracey also confirmed that all the rent arrears on the tenancy had now been cleared, once this was finalised his name would be removed from the tenancy agreement. Tracey said that she felt safe at the property and was aware that she could call the police if she has any further issues, she also had the SIDAS contact number if she should like any assistance from them.

4.8 South Western Ambulance Service NHS Foundation Trust (SWASFT)

4.8.1 The SWASFT covers a geographical area of 10,000 square miles, servicing 5,500,000 people and employs 4,000 staff and over 2,000 volunteers.

4.8.2 All staff and volunteers in the Trust undertake safeguarding sessions as part of their mandatory training cycle including input regarding 'identifying risk in situations of domestic abuse'. Principles of safeguarding are also threaded and embedded into other clinical training delivered through annual refresher training. The Trust's Safeguarding Service supports the Trust's Learning and Development Team to deliver a safeguarding training strategy by providing advice, supervision, quality assurance, and train-the-trainer support.

4.8.3 Frontline staff use an electronic reporting tool on the electronic patient care record device to complete safeguarding referrals. The tool includes a DASH risk assessment proforma.

4.8.4 There were a total of 7 contacts with the family, throughout the period of the review. The IMR author recognises that there were two occasions which presented opportunities to identify, respond to and report risk factors of domestic abuse, specifically these the incident in sections 3.6.9 & 3.6.39. The analysis of performance is completed in section 5.3.6.

4.9 Sedgemoor District Council

4.9.1 Sedgemoor District Council reviewed its contact with the deceased and Tracey. Their research confirmed that SHAL Housing were the accommodation provider, during the period of this review.

4.9.2 Paragraph 4.4.6 details the way in which Housing Benefit, and subsequently Universal Credit was paid to them. At the time the scheme was very new and there were teething problems. Under the Universal Credit scheme, rent payment was sent directly to the tenant rather than the landlord. There was a built in 5-week delay and the first week of the claim is not paid. In the months prior to David's death the family received £1,500 to safeguard the family until rent arrears were paid off and after David's passing Tracey received a similar payment. Details of money's paid are recorded in point 3.6.8 and associated footnote.

4.9.3 Throughout the various financial and housing problems that the family suffered SDC and SHAL housing spent a good deal of time working with David and Tracey. These included matters of rent arrears (as demonstrated above), property repairs, and the court processes when, eventually eviction proceedings began.

5. Analysis

5.1 Issue of Hindsight Bias

As the Overview Report Author, I have attempted to view this case, and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight. Hindsight always highlights what might have been done differently and this potential bias or 'counsel of perfection' must be guarded against. There is a further danger of 'outcome bias' and evaluating the quality of a decision when the outcome of that decision is already known. However, I have made every effort to avoid such approach wherever possible.

5.2 Domestic Abuse/Violence

5.2.1 David had died as a result of deliberately suspending himself by the neck but his intentions at that time were not determined.

5.2.2 Considering the government definition of domestic violence and abuse which describes a pattern of incidents of controlling coercive or threatening behaviour the review panel was not able to determine whether a broader history or a result of a single act caused David to take this action. This conclusion is based on information gathered by this review panel. The collation of the IMR's and chronologies by individual agencies has identified there were problems and issues within the relationship between David and Tracey.

5.2.3 There were several reported incidents of David self-harming. However, these could be generalised as being superficial and potential cries for help. While there were several reported incidents to Avon

and Somerset Police often these were recorded as a domestic incident requiring little police intervention.

5.2.4 David did however visit his GP on several occasions and reported feelings of depression, financial worries and difficulties in meeting the expectations of his family. Often, he was prescribed antidepressant medication and referred to support agencies in order to treat or minimise this condition.

5.2.5 There are also several reported incidents of David collapsing either at home or at work. As a result of speaking with health services he made similar disclosures about his anxieties.

5.2.6 Regardless as to whether there was any wider pattern of domestic violence or abuse or not, it is clear there was an increasing amount of tension, as well as relationship conflict, between Tracey and David. The couple had separated in February of 2017 although David remained on the tenancy of the family home and had keys to the premises. On occasions this caused Tracey some anxiety and anger resulting in calls to the police.

5.2.7 Tragically it is not possible to build a picture of David's perspective in this relationship however he appeared to be juggling family life, with financial expectations, and work commitments. This appeared to be a difficult balancing act for him to achieve and David seemed to struggle with this over several years.

5.2.8 However if David did have wider concerns about his relationship or experienced domestic violence or abuse from Tracey, he appeared keen not to seek support or disclose issues of domestic abuse until faced serious situations, for example arrest and interview by the police. While it was not possible to know, either way, if David did have concerns, which he did not share, if he did then it could be for many reasons including embarrassment, or shame, or feeling that he should be able to cope. The potential barriers to reporting these issues are considered further in relation to gender perception and equality and diversity.

5.2.7 One explanation for David's act may be to focus upon his mental health and feelings of depression, specifically on whether this would account for his decision to take his own life. David was never diagnosed as having any mental health issues. Although he had been prescribed citalopram[15] an anti-depressant. Following several visits to the GP surgery and discussing feelings of depression these and other matters are discussed in section 2.3

5.2.8 However it is also possible to explore this suicide through another lens specifically the sex of those involved. Academic study identifies suicide is the leading cause of death for men under the age of 50 years[16]. It is hard to convey the devastation with just numbers; a suicide is like a rock thrown into the water with the ripples spreading outwards affecting all those who knew him. Both men and women are expected to conduct themselves in certain ways, socially constructed and include behavioural activities and attributes that a given society considers appropriate. Using a gender framework, it is possible to explore how David's ideas of masculinity might feature in the circumstances leading to his death.

[15] https://www.nhs.uk/medicines/citalopram/

[16] https://www.samaritans.org/about-samaritans/research-policy/suicide-facts-and-figures/

5.2.9 Research and statistical analysis show the complex issue of suicide and in a report carried out by the Samaritans organisation in 2018[17] men talked about their relationships breaking down, separation from their children, loss, addiction, a lack of close family friendships, loneliness and being unable to open up to anybody as root causes of suicidal feeling.

5.2.10 David visited the GP surgery to discuss the pressures he felt. Rightly and reasonably, the GP sought to provide David with support including those from statutory and volunteer agencies for example the Samaritans, the Talking Therapies programme operating locally and the Mental Health Home Treatment Team[18] as well as prescribing medication.

5.2.11 Recent research[19] into suicide has explored the importance of suicide triggers, in simple terms suicidal thoughts and behaviours start when vulnerable individuals encounter stressful events. They can become overwhelmed by situation and decide, that suicide is the only reasonable way to stop the pain they are experiencing. Determining what makes events stressful is difficult because everyone copes in different ways, and from different perspectives.

5.2.12 Both positive and negative events can be sources of great significant stress for example, losses related to health, significant relationship and job problems, debt and humiliation. The Office of National Statistics record that in the year up to September 2019 three quarters of deaths from suicide were men[20].

5.2.13 Whilst the limited information in this case means it is difficult to be certain as to the presence of these markers. The prospective of separation or rejection has been mentioned throughout the combined chronology, and the deceased speaks of financial expectations placed upon himself. Also, the combined chronology appears to present a picture of potential homelessness immediately prior to his death. There are also recorded events of significant rent arrears and the expectation is that David will accept responsibility for them.

Learning Point 1. It is important that professionals have a better understanding of how to identify those likely to be at risk. Also, what actions those professionals or local partnerships can take to reduce the likelihood of future suicide of this nature. Additionally, a key purpose of DHR's is to reduce the likelihood of future cases like this. As the Home Office has access to all DHR's, as part of the quality assurance process it can review learning across cases in a way that a single agency cannot.

Recommendation 1: Safer Somerset Community Safety Partnership to seek reassurance that training and CPD strategies reflect:

- Gender dynamics when dealing with incidents of domestic abuse.
- Identify 'triggers' associated with the escalation of domestic abuse.

[17] https://www.england.nhs.uk/blog/tackling-the-root-causes-of-suicide/

[18] Referrals to the Mental Health Home Treatment Team fall into two categories. High Risk matters are referred by the GP and lower risk matters can be referred by any other of agency. This method allows for suitable prioritisation

[19] https://www.gulfbend.org/poc/view_doc.php?type=doc&id=13740&cn=9

[20]https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2018registrations

Recommendation 2: The Safer Somerset Partnership to write to the Home Office with the findings of this DHR suggesting that they undertake further research into cases of suicide with a reported history of domestic abuse where the perpetrators are male, in order to develop a profile of potentially vulnerable men.

5.3 Male Victims of Domestic Abuse

5.3.1 The author wishes to point out that the research and analysis on this subject in no way seeks draw a correlation between David's death and any domestic abuse which was occurring in the family home.

5.3.2 The chair has researched the issue of male victims of domestic abuse and specifically the subject of ethnicity. In the summer of 2019 Safelives carried out a programme to gather voices of men and boys, from all backgrounds who been the victims of domestic abuse[21]. There were over 200 respondents from across the UK and several key findings included that the main dynamics of abuse included, being made to feel small and being blamed for something that was not their fault.

5.3.3 The impact of domestic abuse can be long lasting and leave the victim with many damaging emotions including:

- Anxiety or continuously feeling on edge
- Loss of confidence
- Loneliness and/or isolation
- Embarrassment of shame
- Low self-esteem or worthlessness.

5.3.4 In terms of the Safelives program, mentioned above, over 90% of the responders reported a combination of these emotions. Almost two thirds of the responders reported having suicidal thoughts and one third had self-harmed. 80% of the responders reported that the behaviour they experienced 'affected their mental health a lot'.

5.3.5 In terms of how these statistics translate into this review it would be wrong and inaccurate to try and offer a specific and direct link between the relationship problems David and Tracey were having and his death. However, it is worth noting some of the impacts that the Safelives programme highlights when considering some of the emotions that David reported during the period of time that this review covers i.e.

- There were several occasions where David's emotional and physical health caused an ambulance to be called, suggesting high levels of anxiety.

- On more than one occasion David reported struggling to cope with the expectations placed on him by others.

[21]https://safelives.org.uk/sites/default/files/resources/Men%20and%20boys'%20experience%20of%20domestic%20abuse.pdf

- There were several occasions when David expressed feelings of having dark thoughts and depression but confirmed that Tracey and the children were supportive of him.

- It was shortly before David's death that plans were put in place to repossess the family home due to rent arrears. It seems natural that he would have had feelings of shame and embarrassment that he was unable to prevent this from happening.

- Throughout the period of this review there are reports of David self-harming including the incident the night before his death when David took a knife from the kitchen and threatened the same in front of police officers.

5.3.6 The author of this report has carried out extensive research into the links between Domestic Abuse, suffered by BAME male victims. The Office of National Statistics detail that 3.9% of white men experienced domestic abuse compared with 3.5% of men identifying themselves as of a mixed ethnicity and 3.3% of black men.[22]

5.3.7 However, "the heterosexual male, BME, and LGBT victims of domestic and sexual violence are in different ways 'hard-to-reach' groups"[23] and this suggests, as mentioned earlier, that with 1 in 4 victims of Domestic Abuse being male, more needs to be done to raise this as a national issue in order its causes and symptoms may be explored and solutions found.

5.3.8 It might be easy to suggest that there is a national knowledge gap on the subject of men being victims of Domestic Abuse in the BAME community however the simple fact is that men seem unwilling to come forward and discuss their experiences and this may be reflective (as mentioned above) of men being generally reluctant to discuss their experiences and feelings, particularly on such a sensitive subject.

Recommendation 3: The Home Office to undertake further research into male victims of domestic abuse in the BAME community and raise to awareness of referral pathways for all men who are victims of domestic violence.

5.4 Analysis of Agency Involvement

During the period of this review the Somerset Partnership NHS Foundation Trust (SOMPAR) and the Taunton and Somerset NHS Foundation Trust (TST) worked as separate organisations however since the 1st of April 2020 these two agencies have now merged to form the Somerset NHS Foundation Trust.

[22] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2019#ethnicity

[23] (Gadd, 2002; Batsleer et al., 2002; McCarry et al., 2008)

5.4.1 HEALTH SERVICES -TAUNTON AND SOMERSET NHS FOUNDATION TRUST

5.4.1.1 Prior to the day preceding his death in September 2017 the family had little engagement with TST, in total four occasions including two matters in 2014 for which David was treated, for a cut to his hand and a bad back. These did not relate to issues of domestic abuse and the IMR author records that correct processes were followed during each episode of care. and the panel support this view.

5.4.1.2 On the day preceding the death there were two incidents recorded on the IMR, both involving David. Firstly, he was bitten on the hand and the lip by Jill, following an argument in the early hours of the morning. This was managed, at the scene, by the attending officers with no call to the ambulance service or other health care professionals.

Later in the day Tracey called the ambulance service due to an incident where David appeared to be having a breakdown and had threatened to stab himself. As a result, the police and ambulance service visited the family home. David was advised to go to hospital, but before leaving the address he collapsed and was taken to the Emergency Department, at Musgrove Park hospital. David told staff in the Emergency Department that he had been pushed down the stairs and had a pain on the right side of his face and a headache. Concerns had been raised, by ambulance staff with regards to David's mental state and so following a CT scan and blood tests a decision was made for him to be referred to the Psychiatric Liaison Team (PLT) for review and assessment (See 5.4.2 below).

5.4.1.3 The panel considered the issue of professional curiosity and the circumstances of David's attendance at the hospital's Emergency Department. The task of introducing routine enquiries relating to domestic abuse to a trust with in excess of 9000 staff, many different teams and services, means that the trust does not yet have a blanket routine inquiry process but it is an issue that has been taken to the joint SOMPAR/TST safeguarding committee for discussion. Safer Somerset was also part of a 'Pathfinder' pilot project between 2017 and 2020 (see 5.4.2.14).

5.4.1.4 In July 2019 the Taunton and Somerset NHS Foundation Trust published a revised policy document regarding domestic abuse and this has been reviewed by the chair. The document gives clear direction and expectation with regards to the process to be followed, when a patient attends hospital with a condition or situation that could be related to Domestic Abuse.

5.4.1.5 The document provides step-by-step guidance to front line practitioners including the use of professional curiosity, actions after disclosure, the use of MARAC and onward referrals. The chair wishes to add his full support to the content and spirit of the policy and believes that its full implementation would go a long way to identifying and supporting domestic abuse victims who attend the merged Somerset NHS Foundation Trust services.

Learning Point 2. The panel takes the view that there is an opportunity for the staff at the Musgrove Hospital Emergency Department to demonstrate more professional curiosity when dealing with victims of assault. David had disclosed to staff, that he had been pushed down the stairs at home. Also, there were concerns for David's mental well-being, raised by the ambulance crew upon arrival at the hospital.

The IMR author makes a recommendation which seeks to remedy this, and it is recorded in Appendix two and supported by this review.

5.4.1.6 Lesson Learned – Regarding the incident on the day prior to the death

After David left the A&E department, there was no subsequent follow up either at home or via phone call. The process at the time would be to note concerns in the 'Safeguarding book' which is held within the A&E Department, it appears that this did not happen.

SOMPAR has now changed its processes when dealing with patients in similar circumstances:

1. When patients present symptoms raising concerns about their mental health but leave Emergency Departments before being assessed then a notification is sent to the GP surgery. - This process is related to presentations of possible domestic abuse, whereby patients who present with signs of DA or disclose DA, but who decline to discuss it further have a notification sent to their GP surgery.

2. Emergency Department staff receive DA training as part of their safeguarding adult training. However, there are ED staff who have registered an interest in becoming Domestic Abuse Link-workers (DALs) within the Trust and will received DA training up to Level 3. This is a new development that has evolved from the Trust's participation in the Pathfinder Project.

5.4.1.7 Lesson Learned Male victims of Domestic Abuse

Hospital staff receive Domestic Abuse training at 3 different levels:

a. Level 1 training is aimed at those who may have indirect contact with patients
b. Level 2 and 3 training is for those who have direct involvement with patients
c. Level 3 training is particularly bespoke to those in specialist roles.

Each of these training sessions now has an input into the issue of male victims of Domestic Abuse and Intimate Partner Violence.

5.4.2 Health Services - Somerset Partnership NHS Foundation Trust (SOMPAR)

5.4.2.1 The primary involvement of SOMPAR with regards to this review was its health visiting service. Initial contact with Tracey and David disclosed a previous history of domestic abuse before moving to the area. The couple also raised concerns about the behaviour of Child 2. However there have been no recorded incidents since moving into Somerset.

The review panel were interested in how this information was recorded and subsequently shared. The IMR author recognises that this is an opportunity to enhance performance. So raises an action for staff to clearly document the source of historic domestic abuse, relevant details and whether the information provided can be substantiated.

5.4.2.2 Following initial engagement, Tracey received further contacts from the health visiting team primarily under the 'universal services'[24]. However, this contact transitioned to Universal Partnership Plus[25] due to the involvement from the CSC, following the disclosures made by Child 1.

5.4.2.3 Following the disclosure, from Child 1, the SOMPAR safeguarding children's nurse participated in a telephone strategy meeting on the 7th of January 2014. It was agreed that the school nurse and health visitor were to be informed of this case and the concerns raised. The health visitor followed this up with a telephone call to Tracey and David, and an appointment was made for an antenatal visit.

5.4.2.4 During this visit, the following day, Tracey disclosed that her brother had recently died taken his own life. She told the health visitor that although she was grieving for him, she was not depressed. Liaison between the health visitor and the children's social worker took place on 24th January and it was confirmed the following day that a Children and Family Assessment was to be undertaken. The review panel considered this course of action and agreed that under these circumstances the assessment was entirely appropriate.

5.4.2.5 Both agencies were worried that Tracey would continue with this style of discipline, and Child 1 may feel frightened and end up injured, both physically and emotionally. The CSC was satisfied that Tracey acknowledged why she shouldn't hit Child 1 and were pleased that she had agreed to stop. Both CSC and the school were pleased that Tracey was willing to talk to her health visitor about support with parenting, particularly with regards to the subjects of discipline, routine and boundaries. The school's Parent and Family Support Advisor (PFSA) began working with Child 1 to provide a safe place to talk about any worries, wishes and feelings. It was agreed that the school would refer Child 1's case to CSC if any further welfare concerns arose.

5.4.2.6 The assessment was concluded when it was identified that all three children were achieving the expected outcomes for the stages of development. Universal services (school and health) were able to provide support to the family, and therefore there was no further role for the CSC to play. The case was reviewed, and the conclusion agreed.

5.4.2.7 Following a Domestic Abuse notification from the police to the health visitor in November 2015, several attempts were made to contact Tracey. This included an ad hoc home visit; however, it was established from the occupant of the address they visited that Tracey had moved. This created a request via the CSC to identify Tracey's new address. New details were provided however further attempts to contact Tracey there were also unsuccessful.

5.4.2.8 SOMPAR had no further contacts with either the deceased or Tracey until July 2017. At this time three separate notifications were received. The first contact related to a progress note from the Mental Health Triage Team. A second notification came regarding attendance at the family home following reports that David had been self-harming, (the SWASFT notification was forwarded onto SOMPAR and reported that David had been self-harming as an act of anger and with no intention

[24] All children have access to a range of 'universal' services depending on how old they are, their stage of development and their individual needs. Universal services are provided by several different agencies, including health and education. health visitors, GPs and school nurses are all examples of universal services.

[25] Universal Partnership Plus provides ongoing support from the health visiting team, bringing together a range of local services, to help families who have complex additional needs.

to end his life, he had refused to go to hospital due his concerns are with children). Thirdly there was a report, from Tracey that David had been to the address and threatened her friend. On each occasion the health visitor attempted to contact the client, without success. SOMPAR records reflect that information sharing entries were made prior to this period.

5.4.2.9 The final contact with SOMPAR occurred immediately prior to his death in September 2017, whereby David was an alleged perpetrator of domestic abuse. On this occasion there were concerns about his mental health and therefore he was taking to the Emergency Department at Musgrove hospital whilst there he was referred to the Psychiatric Liaison Team for an assessment of his mental health. However due to the volume of referrals on that day, with only one staff member being on duty, the PLT weren't able to see him instantaneously however when they did arrive to see him, David had reportedly changed his mind about being seen and left.

Learning Point 3. The panel recognised there were opportunities here for David to receive potential support prior to leaving the hospital. For example, being provided with a leaflet explaining the role of the Psychiatric Liaison Team and to be provided with contact details for community support including mental health services.

This has been raised by the IMR author, as an action and recommendation, on behalf of their own agency and the TST, the panel and the chair support this recommendation.

Good practice

5.4.2.10 In addition to the Learning Point above there were also opportunities to contact partner agencies including the police to request a welfare check be carried out at the patient's home address. This would provide better information sharing particularly as David at the time was suspected of a domestic abuse assault. This has been raised by the IMR author, as an action and recommendation, on behalf of their own agency, the panel and the chair support this recommendation.

5.4.2.11 The panel discussed the issue of resourcing in the PLT. It was confirmed that following the death of David a review was completed by SOMPAR and it was agreed that staffing levels needed to match demand. Since January 2018 the PLT has undergone a period of transition enabling the provision of increased staff cover for both Musgrove Park and Yeovil District Hospital which potentially enables the hospital's access to more staff; thereby reducing waiting times for mental health assessments within ED.

5.4.2.12 Similar to the TST, SOMPAR also has a domestic abuse policy and provides similar advice to health care worker and other front-line practitioners working with families and the vulnerable. It advises staff that questions about domestic abuse must be asked routinely, if safe to do so, and as part of a clinical assessment. The outcome of these questions should be documented on the patient record. If disclosure of domestic abuse, is made, then staff are advised to complete the DASH risk assessment, and a record should be made on the internal electronic patient records. The policy also identifies potential pathways to support victims on the vulnerable including the local Somerset Survivors helpline and other national agencies. These details should be readily available to those disclosing domestic abuse.

5.4.2.13 The domestic abuse policy document also gives clear guidance with regards to staff training. This includes induction training and access to similar training which must be completed within six months. There are also specific domestic abuse courses available through the local authority.

5.4.2.14 It is clear from this document that all training is mandatory with specific timeframes for completion. This is also highlighted within the TST policy document. The chair has had an opportunity to review this paper and wishes to add his full support to its content and the spirit in which it is presented. The chair believes that its full implementation would go a long way to identify and support domestic abuse victims.

Recommendation 4. Ensure that training packages are prepared and delivered in accordance with the guidance and directions provided within the SOMPAR DA policy.

5.4.2.15 Lesson Learned - Pathfinder

Since the death of David, Safer Somerset has taken part in a national pilot project called Pathfinder. The details are recorded below, and it is mentioned in this report as it is believed that its introduction will enhance the opportunity for those engaging with primary health care professionals to disclose and seek support in domestic abuse matters.

This a pilot project that ran in a number of location across England from 2017 to 2020 and was led by Standing Together as part of a consortium of expert partners, including Safe Lives, Imkaan**,** Against Violence and Abuse (AVA)**,** Identification and Referral to Improve Safety (IRISi) and Standing Together Against Domestic Violence (STADV). It engaged nine clinical commissioning groups (CCGs) and 18 NHS Trusts across England to implement sustainable interventions in eight local areas: Blackpool, Exeter & North Devon, Haringey & Enfield, Somerset, Three councils (Kensington & Chelsea, Westminster and Hammersmith & Fulham), Camden & Islington, North Staffordshire, and Southampton.

Somerset CCG led on the implementation of this project, in its Trusts between 2019 and 2020

The findings of the Pathfinder pilot informed The Whole Health Model[26], which aims to transform healthcare's response to domestic abuse by ensuring a coordinated and consistent approach across the health system including acute, mental health and primary care services. The model supports health care services to work with the local domestic abuse specialist services to commission integrated care pathways and build the capacity of all health staff to respond safely to survivors of domestic abuse.

The interventions and approaches pioneered and tested across these various sites highlight the benefit of the Whole Health Model. The Pathfinder toolkit incorporates the key components of this model into a comprehensive and sustainable response to domestic abuse within health. It provides detailed guidance for health care leaders to deliver the model. This includes structure and organisational strategy, the development of policy and the co-location of health based IDVA's, the establishment of a domestic abuse coordinator, as well as a domestic abuse champion's network. The toolkit also includes staff training, data collection, patient information campaigns and the establishment of a referral pathway to local services.

[26] https://www.standingtogether.org.uk/pathfinder

In practical terms the Pathfinder pilot provides staff with the tools, support and training materials to enable them to identify and refer patients, when they present to the trusts with trauma that may have arisen from domestic abuse. Pathfinder allows the opportunity for systematic change and deliver of Trust specific training and support. It is worth pointing out that due to the COVID-19 crisis, training has been delayed but will be restored.

In Somerset the Pathfinder project resulted in the production of a "Health" domestic abuse policy and procedure. This enables staff to respond effectively to people presenting with trauma arising from Domestic Abuse. Two training programmes were also developed for use in acute services. At the time of writing over 70 staff across the trusts have registered to become a Domestic Abuse Link worker. This is something they have volunteered to do on top of their everyday role. The link workers will receive additional training so they can support staff to give the most effective response to people who are experiencing Domestic Abuse

5.4.3 Health Services - General Practice (via CCG)

5.4.3.1 The IMR's chronologies presented by the CCG during this review period have identified 13 contacts of interest. These include various visits at the GP surgery, including presentations by David when he discussed feeling depressed, problems at home and other stressful triggers. There are also four reported referrals sent to the GP surgery by Avon and Somerset Police. It should be noted that a good deal of the stress that David discusses relates to the fact that he was being prosecuted by the police in 2015.

5.4.3.2 There are attendances at the GP surgery in January 2015 where David talks with the doctor about having dark thoughts and incidents of self-harming. However, he also mentions the fact that these were sporadic periods of anger. Stating he would never consider them to be anything other than moments of frustration, and that he never intended to take his own life particularly as Tracey's brother had done so only a couple of years earlier. In these conversations he describes Tracey and the children as a source of strength.

5.4.3.3 During all of these visits the GP provided support and empathy to David's emotional state, including various referrals to statutory and voluntary organisations such as the Samaritans, the Mental Health Crisis Team and Talking Therapies. Further analysis and research identified that David chose not to pursue any of these proposed referrals. In December 2016 the GP diagnosed David as being depressed and prescribed him with antidepressants as part of the plan to manage his emotional state.

5.4.3.4 The chair of the review has held discussions with the CCG panel members, particularly with regards to setting out any additional responsibilities which GP practices may have had beyond clinical diagnosis and treatment in relation to Domestic Abuse. These responsibilities are described as follows. The GP practices have responsibilities to identify and treat patients with the symptoms they present, and to make appropriate referrals to supporting agencies. As is the case for any other health professional, if a person presents at GP surgery and there is a sign or suggestion that Domestic Abuse is occurring then then it is reasonable that the GP ask validatory questions and reassure the person that they are believed. A GP should also assess the risk of the situation. The practice then takes any appropriate action, wherever possible, to enable that patient to access help, based on the level of risk that he/she presents. This might include signposting the person to Domestic Abuse Services, or

arranging a follow up appointment with a member of the practice team to enable the person to access other services. When the level of risk is high, a DASH should be completed and sent, as a referral for MARAC, and the local Domestic Abuse Services.

5.4.3.5 The role of the GP is to enable the person to disclose and keep offering opportunities to disclose. Also providing safety advice, signposting to services and where appropriate making onward referrals. The role of a GP practice is not to provide a service of support or resolve the person's situation. This would be provided by SIDAS.

5.4.3.6 "Routine Enquiry" means that all people are automatically asked if they are experiencing Domestic Abuse with every initial/new contact with a service. GP's undertake consultations with people who have a whole range of health needs. So, unless there are particular indications of Domestic Abuse, the GP would not make a routine enquiry with all patients presenting with every health need. As a general approach, it would be good practice to make routine enquiries at antenatal and post-natal checks, contraceptive review, treatment of sexually transmitted infections, unplanned pregnancies and when the person presents with medical symptoms that cannot be explained.

Learning Point 4. There was an opportunity to make enquiries during a couple of consultations, such as when David alleged, he was pushed down the stairs. This is a learning point for the surgery about recognising someone, particularly a male who is experiencing Domestic Abuse.

5.4.3.7 The chronology identifies that the practice received a cluster of reports from the police shortly before David took his own life. It is reasonable to expect the GP practice to review such reports due to the content and in the context of any recent contacts, in order that they can determine if any urgent action needs to be taken. It is good practice to raise these at internal meetings where patients who are at risk of abuse or neglect are discussed. If required, a plan is agreed about how to contact the family, who is best placed to do so and whether any onward referrals should be made.

5.4.3.8 It is also recognised that if a patient discloses or infers matters of domestic violence or abuse the GP would be expected to carry out enquiries. There is no scripted process for these enquiries as the GP's are expected, to use their professional expertise and judgement based on the individual's circumstances. Broad questions might be used to open conversations in the first instance for example "How are things at home?"

5.4.3.9 GP surgeries hold Multidisciplinary Team Meeting (MDT)[27], where safeguarding and domestic abuse issues may feature. They also have specific practice safeguarding meetings This allows doctors to raise cases where safeguarding or domestic abuse maybe a concern. Additionally, GP computer system's allow cases where domestic abuse has been identified or suspected, to be flagged for future reference. It would be useful to understand details of the reports made to the police. In these cases, closer liaison between the agencies would improve the service to domestic abuse victims.

5.4.3.10 At the conclusion of this piece of analysis it is worth pointing out that this incident occurred almost 3 years ago and since then the CCG has continued with a training programme for GPs in relation to Domestic Abuse. This has included in refresher and update training.

[27] A multidisciplinary team meeting is a meeting of a group of professionals from one or more clinical disciplines did you get to make decisions regarding recommended treatment or referral for individual patients. Multidisciplinary teams may specialise in certain conditions such as cancer.

Learning Point 5. Recent police reports should trigger routine enquiries about domestic circumstance and/or discussion with practice safeguarding lead and/or discussion in practice safeguarding/complex case meetings. If appropriate further enquiry's and possible onward referral e.g. to SIDAS Somerset Integrated Domestic Abuse Service.

Recommendation 5. Avon and Somerset Police to improve monitoring of reports to identify domestic abuse trigger's and, if appropriate, carry out further enquiries and possible onward referrals to GP surgeries

Learning Point 6. A variety of effective interventions can make it easier for GP and NHS services to play their part in reducing domestic abuse and identifying the vulnerable. This should include access to training support and a referral programme in order to support them asking about and responding to domestic violence and abuse. This has already been implemented by the CCG over the past three years and is monitored through the annual safeguarding report that GP practices are required to return to the CCG. This annual safeguarding report includes information about Domestic Abuse.

5.4.4 CHILDREN'S SOCIAL CARE

5.4.4.1 The initial contact between the family and Children's Social Care began on the 7th of January 2014 with their engagement in a children and families assessment, the details of which are discussed previously in this report. The outcome of this assessment led to a recommendation on the 25th of March 2014 that no further action was necessary.

5.4.4.2 An analysis of the combined chronology and the input from the CSC recognises there were long gaps between reported incidents. The question could be asked was this because some incidents were not reported, or that domestic violence did not occur? This was not explored by the social worker or evidenced in the Children and Family assessment and there is no demonstration of professional curiosity throughout the assessment.

Child and Family Assessment

Following a referral the purpose of a Child and Family Assessment is to gather enough information about a child and their family to understand the need and make decisions.

- *The nature and impact of the concerns or needs described in the referral and what intervention or support is necessary.*
- *Whether the child meets the criteria for ongoing services as a child in need (CIN).*

The maximum time scale of 45 days from the point of referral to completion allows flexibility and the individualisation of responses. But the pace of an assessment should be determined by the needs of the child and the presenting risk, the assessment must include visits to the child.

Somerset Safeguarding Children Partnership has produced a guidance document entitled 'Effective support for children and families in Somerset[28]*. It aims to assist practitioners and managers in assessing and identifying a child or young person's level of need. What type of service or resource is required to meet those needs, and the process to follow in moving from an identification of need to the provision of services with the aim that the child receives the right support, in the right place, at the right time. It introduces a continuum of need and support. Providing information on the levels of need and give examples of the factors that may indicate a child or young person, or their family may need additional support.*

In this case the child and family assessment identified that the Children Social Care offices at the couple's previous home in the Midlands, had been involved as a result of two domestic incidents involving Tracey and David. Their involvement ended in November of 2012 with the family moving to Somerset.

The referral from Child 1's school related to:

- *The nature of Tracey's discipline towards Child 1*
- *The fact that Child 1 had come into school late and once in school had appeared to be very upset and tearful.*

Enquiries were carried out under section 47 of the Children's Act 1989[29]*, these enquires revealed both positive and negative details.*

<u>What was working well</u>:

- *The health visitor had no concerns of the welfare of the three children and she had enough support to carry out low key work around behaviour and discipline with both parents.*
- *The school had raised no welfare concerns about Child 1 other than the incident that had been raised.*
- *Tracey had agreed that Child 1 can receive support from the PFSA around emotions and feelings and that Child 1 had been placed on a waiting list for this work to commence.*
- *Child 1 reported having a positive relationship with David and maternal grandmother. Child 1 also reported that Tracey doesn't smack Child 1 anymore, both Child 1 and Child 2 have positive relationships with each other and had age-appropriate friends. Child 1 also confirmed that can talk to a grandmother and teacher if they have any concerns.*

<u>Concerns which generated the C&F Assessment</u>:
The nature of the disclosure made by Child 1 created anxiety for both the CSC and school. The focus of this concern is that it is known that children witnessing or experiencing aggressive behaviours in the home can affect the emotional well-being of the child at the time and in the future. With children feeling scared and frightened and they copy these behaviours with their peers and have difficulty in coping with their own anger management and upset. This may affect the child's ability to make and sustain appropriate relationships and cause them to exhibit challenging or disruptive behaviour.

[28]https://sscb.safeguardingsomerset.org.uk/download/2632/

[29] Section 47 of the children's act 1989 where a local authority has reasonable cause to suspect that a child suffering or likely to be suffering significant harm another duty to make such inquiries it considers necessary to decide whether to take action or safeguarding promote the child's welfare.

5.4.4.3 The IMR author records that within this C&F Assessment there is no reference to domestic violence. However, it is documented in the 'circumstances' section that there was a history of domestic abuse earlier in the couple's relationship. Within the 'Factors Identified' section of the assessment the box relating to domestic abuse factors is ticked "no". There's no correlation between the abuse alleged by Child 1 and any violence at home. The assessment was allocated on 10th January 2014. However, no contact was made with the CSC from the area where the couple previously lived until the day of the C&F decision and closure on the 25th March 2014. It is unclear whether the social worker was aware of the couple's previous address. This appears to have been a missed opportunity to explore both parental and children's relationships in greater depth.

5.4.4.4 In November 2015 the CSC received a complaint and referral that David had thrown a mobile phone at Tracey injuring her hand. At the conclusion of the police investigation the decision was made to charge David with assault. Following the appearance at court David was bailed with conditions not to contact anyone at the family home. There was a further condition that any contact, with the children must be through a solicitor. Bearing in mind these conditions CSC took the decision to take no further action with regards to the safeguarding and safety of the three children. The panel takes the view that this was a reasonable and proportionate decision. There was a further incident in December between Tracey and Jill however no subsequent prosecution was ever pursued, and the CSC took the view that Tracey was safeguarding the children appropriately in order to protect them should circumstances escalate. Concerns over the safeguarding of the children should have been investigated more thoroughly including interviews with them and both parents separately. The panel takes this view based upon the general lack of professional curiosity demonstrated by the social worker.

5.4.4.5 Following the EHA in February 2017 and the recommendation for level 3 Get Set Services, David and Tracey both asked for time to consider their options. This has been interpreted, with the benefit of hindsight, as being an action of 'disguised compliance leading to ultimate avoidance': that is to say David and Tracey appeared to want to pacify supporting agencies with the aim of avoiding any engagement. The panel takes the view that this could have potentially been monitored between the CSC and Get Set staff. Or with follow up phone calls, emails or other communication pathways. Therefore, this appears to be an evident gap in communication between agencies.

Lessons Learned

Following an internal restructure Somerset County Council's (SCC) early help and support is now the responsibility of the Family Intervention Service (FIS). The FIS is a specialist county-wide service and offers support to children and young people aged 0 to 18 years and their families, (where needs are present at level 3 and level 4 of the Effective Support for Children and Families in Somerset guidance).

The service provides increased flexibility over operating hours and aid co-ordination by operating between 7am to 10pm. This includes a duty service for over 10s in crisis after 5pm and at weekends. Rapid Response service operates between 10pm and 7am, Friday to Monday and there is generally an Emergency Duty Team call out service. There are two Family Intervention teams in each of the four-district council areas and there are a total of 8 teams. They work closely together with partners and communities to provide effective support for families experiencing complex issues with a better, more focussed use of the Council's resources in meeting family needs.

The FIS only work with families where informed consent has been gained. Practitioners will be open and honest with families about why it is important to share information, who with and how it can help and support meeting the needs of a family to effect the change they have identified.

The target groups are families experiencing complex needs where at least two of the Level 3 indicators, or similar, are evidenced. The team may work with families where an individual over 18 has Special Educational Needs, is at risk of homelessness or where younger children are in the home subject to team capacity and local managerial agreement. Partners should make requests for consideration of a service through the Early Help Hub using the EHA indicating they are requesting consideration of a level 3 service.

At Level 4, a planned, intensive, and individualised intervention of up to 12 weeks with the option to extend up to 24 weeks alongside and in partnership with CSC. This can be a planned package of support for a young person aged 10 -18 years or shorter intervention to help stabilise a crisis whilst the lead professional carries out assessments to identify longer term planning and intervention. For children under 10 – the social worker needs to establish the specific needs for a FIS service and discuss this with their line manager and Operations Manager for agreement.

As a level 4 service, CSC are case holders for the family intervention work with FIS being a complimentary involvement. FIS workers work closely with social workers to establish the best outcomes for the families we work with. Out of hours work should be referred only when normal social work practice has been exhausted on that day or needs complimentary input by a Family Intervention Worker. Rapid Response work will be referred directly from the Emergency Duty Team.

5.4.4.6 Following the allegations made on the 5th July regarding David assaulting Tracey, a new Social Worker was allocated to the family and given a three-week deadline to complete a Child and Family assessment. However, this assessment was not completed until mid-September 2017, i.e. several days after David's death. The assessment did not consider the children's views, or the views of the ambulance staff about their observations of the children whilst in Tracey's care.

5,4,4.7 In fact, the assessment refers to the social worker observing positive relationships. David does feature briefly within the assessment, but his voice is not balanced compared to Tracey's involvement and there appears to be a lack of consistency within the quantity and quality of considered information.

5.4.4.8 The issue of a lack of professional curiosity occurs again in August 2017. When following reports of a verbal argument between Tracey and David, there appears to have been little evidence that either of the adults or the children were spoken to by the CSC. During the recorded home visit on the 25th August CSC records show a report by the social worker, with clearly contradictory comments within the family, however these were not challenged at the time or subsequently. This is another missed opportunity to explore parental relationships and the children's experience.

5.4.4.9 The IMR author records that during the periods of C&F assessments between January and March of 2014 there are issues of a lack of supervision.

5.4.4.10 Both CSC's IMR and subsequent conversations have identified that there were eight opportunities potentially for CSC workers to complete an assessment of the risk presented. It appears that none of these opportunities were ever seized. This includes a general lack of information sharing and

professional curiosity throughout their engagement. The social workers involved appeared to have had several chances to delve deeper into the relationships within the family.

5.4.4.11 However, these do not seem to have been explored. The review can find no evidence of any independent engagement with the three children to understand the impact that these various domestic incidents had on their upbringing.

5.4.4.12 In fact, the IMR author draws the conclusion that following the disclosures made by Child 1 at school that in fact Tracey was physically and emotionally abusive towards Child 1. This was never explored, and Tracey did not appear to wish to engage with support services and attempted to allay professionals' fears when spoken to. There are examples of 'disguised compliance' to deflect attention away from issues within the family.

Learning Point 7. The review recognises the principles of taking a holistic view when dealing assessments such as these. Professional curiosity is a skill that needs to be developed to seek every opportunity to understand the issues and challenges faced by all families in these circumstances. There were various missed opportunities here including the lack of interviews of the children 'independent' of their parents, the use of a DASH risk assessment and referrals to Somerset Independent Drug and Alcohol Service following disclosures about Tracey's use of controlled substances following her brother's death. There have been recommendations, made during previous local DHR's, with regards to professional curiosity and this review seeks to support them i.e. from DHR 022

Recommendation 6. Safer Somerset Partnership in support with the Domestic Abuse Board to seek assurance in asking all agencies to provide evidence that they include professional curiosity in their safeguarding training i.e.

i. Describe how your agency ensures professionals are confident/able in demonstrating professional curiosity.
ii. Demonstrate that your agency/service's safeguarding training includes professional curiosity within content.

Learning Point 8. The review raises the issue of information sharing and this has been a subject of concern during many previous DHR's. It seems to be a crucial function of all assessments including Children and Families processes, that those engaging with families have access to all reasonable pieces of information, and able to share it appropriately. This will often involve consent of the parents and be subject to all suitable safeguarding measures.

Recommendation 7: Domestic Abuse Board supported by Safer Somerset Partnership to improve the effectiveness of all relevant information sharing pathways in relation to domestic abuse and ensure that frontline staff are aware of the opportunities available to them and the ethical and legal ways all sharing information that they receive.

Learning Point 9. The review raises the issue of information sharing and this has been a subject of concern during many previous DHR's. It seems to be a crucial function of all assessments including Children and Families processes, that those engaging with families have access to all reasonable pieces of information, and able to share it appropriately. This will often involve consent of the parents and be subject to all suitable safeguarding measures.

Recommendation 8: The CSC should reinforce the need for the interview of children in domestic abuse circumstances.

Learning Point 10. An NSPCC fact sheet prepared in March 2010[30] gives some guidance in relation to disguised compliance, this involves a parental carer giving the appearance of cooperating with child welfare agencies to avoid raising suspicions to ally professional curiosity and ultimately to diffuse professional intervention. In the Victoria Climbié inquiry, Lord Laming (2003)[31] suggested social workers needed to practice "respectful uncertainty", applying critical evaluation to any Information they receive and maintaining an open mind. It appears that in both C&F assessments David and Tracey were keen to present their family in a light which would satisfy frontline staff that they weren't in need of any support or help.

Learning Point 11. In October 2019 the Somerset Safeguarding Children's Partnership produced guidance[32] for all those who work with children and families, contained within is a short reference in relation to disguised compliance. These details should be used to train frontline practitioners and managers about their responsibilities and the principles in managing situations where this is apparent.

Recommendation 9. CSC to improve the availability of training for frontline practitioners and managers about their responsibilities and the principles in managing situations where disguised compliance is apparent.

5.4.4.13 The IMR author has reviewed the internal recording framework and identified issues of supervision and management In July 2017 the social worker allocated to the family was tasked to complete the C&F assessment with a three-week deadline. This assessment was not completed until the 13th September 10 weeks after the initial task was set. This falls outside of the 45-day expectation for completion of such an assessment. The IMR author also raises concerns over the content and quality of the assessment, which does not appear to have been picked up on at the management level.

5.4.4.14 It's also recorded that during the C&F assessment in 2014 there are two supervisory entries. It is unclear whether this is an appropriate amount of governance for the 70-day period which the assessment appears to have taken. However, during a similar assessment process in 2017 there appears to have been no supervisory recording between June and September, until an overview entry on the 6th September exploring missing information.

Learning Point. 12 During their research the IMR the author identifies a lack of documented supervision and little in the way of strategy setting or support for the allocated social worker. There

[30] https://lrsb.org.uk/uploads/nspcc-fact-sheet-disguised-compliance.pdf

[31] Laming, Lord, (2003) The Victoria Climbie inquiry: report of an inquiry by Lord Laming (PDF). Norwich: TSO P205.

[32]https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=10&ved=2ahUKEwibyomL2LXpAhWSSxUIHawpAzUQFjAJegQIAxAB&url=http%3A%2F%2Fwww.somerset.gov.uk%2FEasysiteWeb%2Fgetresource.axd%3FAssetID%3D62499%26type%3Dfull%26servicetype%3DAttachment&usg=AOvVaw20a7Uz_jqZ4Yfv6kmi5dS3

is a clear inference of missed opportunities at various stages in the reviews and these may have been more easily identified and resolved with regular focused documented professional discussions between frontline practitioner and supervisor.

Recommendation 10. The CSC to improve governance protocols and if necessary, introduce a review framework detailing contacts, current risk and plans, going forward.

5.4.5 Somerset Independent Domestic Abuse Service (SIDAS) – (Livewest)

5.4.5.1 Following the incident on 5th July 2017 where Tracey alleged that David had assaulted her, and he was arrested, a referral was made, by the LSU, to SIDAS. This referral was received on the 11th July. The purpose of the referral was to offer support to Tracey as a victim of Domestic Abuse. A Victim Care Worker was appointed on the same day. Despite several efforts there was no contact until the 21st July, after referring back to the LSU it was identified the number being called was incorrect.

5.4.5.2 A mobile number was provided for Tracey and contact was immediately made. Tracey confirmed her relationship with David was over and that she did not require any of the services available from SIDAS. She also confirmed that there was no CSC involvement with their family and was aware who to contact should she require support. There is no further contact with Tracey, and SIDAS never had any involvement David.

5.4.5.3 In terms of lessons learned or recommendations the only issue arising is in relation to the details with that were provided, in order to contact Tracey. The panel has identified this from a very early stage, and it has been confirmed the changes have already taken place.

Lesson Learned
In similar circumstances now a domestic abuse worker will make one attempt to contact the victim. If this is unsuccessful an immediate referral is made back to the originating agency in order to confirm that the contact details provided were accurate. The review panel takes the view this is resolved the issue.

5.4.5.4 It is noted that from the 1st April 2020 Livewest is no longer the commissioned provider for SIDAS and in fact the contract for SIDAS has been passed to 'The You Trust'. The panel has confirmed that this learned lesson has been passed on to the new agency, and it has been confirmed that a similar working practice has been adopted.

5.4.6 Emergency Services - South West Ambulance Service NHS Foundation Trust (SWASFT)

5.4.6.1 The SWASFT had approximately 7 engagements with David or Tracey some of which appear to involve allegations of domestic abuse. The records that were supplied by this agency state concerns over child welfare, the stress which David was feeling, reports of substance misuse and David's concerns for the safety of the children.

5.4.6.2 On 26th June 2017 upon receipt of the emergency call, clinicians demonstrated good professional curiosity. In the context of the short duration of a 999-call attendance, they identified risk factors of

potential domestic and child abuse and reported these by completing a contemporaneous safeguarding referral. The referral was processed by the Trust's safeguarding team and passed to the Police, Children's Social Care, the GP and the Named Nurse for Safeguarding for community services.

This an expected level of care and expected outcome, in accordance with the Trust's Safeguarding Policy and safeguarding training which ambulance clinicians receive. The ambulance crew witnessed the differing emotions of the children both in Tracey's presence and in her absence and. Jill raised her concerns over Tracey's behaviour and lifestyle and the ambulance crew received similar accounts from David. During an incident in June 2017 the ambulance crew reported Tracey becoming aggressive towards them to the extent that they called the police.

5.4.6.3 There is nothing in the documents provided by the SWASFT to suggest that the performance of the ambulance crews during these incidents was anything other than proportionate and appropriate. However as there is no representation from this agency the panel itself feels it appropriate for questions to be raised in order to ensure the SWASFT safeguarding policy has been adhered to.

5.4.6.4 The chair has accessed the safeguarding policy[33], which was published in September 2018, and therefore does not cover the period of this review. However, the panel feel it is important to be reassured that its current processes and policies are being adhered to. Particularly, with regards to multi agency engagement and information sharing.

Learning Point 13. The policy refers to the process to be followed in the event of attendance at an incident and why domestic abuse is believed to be a contributory factor. Based upon the details provided the panel seeks the following reassurances.

Recommendation 11. Reinforce the necessity to record contemporaneous notes at the scene of domestic abuse incidents and a referral is made to Trust Safeguarding Team within the 48-hour time scales which SWASFT policy requires.

5.4.6.5 The Safeguarding policy also raises the expectation that the Trust Safeguarding Team engages with external and internal partners whenever safeguarding issues arise. In this case it would appear to have been appropriate to refer to the Police, GP practices, CSC, and potentially health visitors. Representatives (on this panel) from those agencies have not recorded or reported any contact with the SWASFT Trust Safeguarding Team, despite SWAFST reporting that this was the case..

Recommendation 12. That the Trust Safeguarding Team ensure that information sharing procedures are effective so that there's engagement with external and internal partners, whenever safeguarding issues are raised, in timely and proportionate manner.

5.4.6.6 The Trust safeguarding policy also sets an expectation that when staff attend an incident and there is a concern with regards to domestic abuse, various procedures ought to be followed. Primarily care and attention to the condition for which they were called. However, the policy refers to the completion of a DASH risk assessment where practical. The records presented by the SWASFT indicate that on at least one occasion there were opportunities to discuss safeguarding issues and vulnerability with David, Jill and Tracey. The panel does not see reference to a DASH being completed or attempted during this period.

[33] https://www.swast.nhs.uk/assets/1/safeguardingpolicy.pdf

5.4.6.7 This IMR author has identified this as an issue themselves. Despite the introduction of electronic care records systems, including access to various reporting processes (including DASH) staff may lack confidence and experience in completing DASH risk assessments. Previous reviews and feedback have highlighted this. As a result, a specific training module on domestic abuse, in particular the use of DASH assessments, has been built into the 2020/21 mandatory refresher training programme. This will aid development of practitioner skill in this area.

Learning point 14. Often domestic abuse incidents are as a consequence or have an outcome of violence and therefore perpetrators are reluctant to contact the police directly. Thus, ambulance services can be the first point of contact. Therefore, it seems reasonable that, where circumstances allow, efforts should be made to complete with a DASH risk assessment particularly if patients are removed from the scene of the incident and the injuries allow for this conversation to take place.

Recommendation 13. Develop the training available to staff so that they are aware of how to complete DASH risk assessments

5.4.7 SEDGEMOOR DISTRICT COUNCIL

5.4.7.1 Sedgemoor District Council's records confirm that David and Tracey moved into the area in 2012 and remained resident's up until the point of David's death. A review of the internal documents confirmed that the family moved to a new house in July of 2015 following the birth of Child 3.

5.4.7.2 SHAL Housing is a community-based housing project in the Sedgemoor District Council area. Those seeking council accommodation visit the Homefinder website and identify properties which they wish to 'bid' for. There is a process of assessment in order to match a family to a property. The panel has identified that SHAL is a small business employing less than 20 members of staff and was David and Tracey's social housing landlord at the time of his death. The chair has discussed the levels of training for SHAL staff and been reassured that it is provided to all employees.

5.4.7.3 SHAL is a passionate supporter of reducing domestic abuse among its residents and encourages all staff and contractors to report their observations and suspicions of possible domestic abuse.

Learning Point 15. In order to support families and uplift SHAL's reputation as an agency who supports the reduction in domestic abuse the chair feels that it would benefit from formal Domestic Abuse accreditation.

Recommendation 14. The CSP should consider providing funding to support SHAL and other housing providers bid to receive formal Domestic Abuse accreditation in order to raise its profile, provide reassurance to the vulnerable and discourage perpetrators..

Learning Point 16. SHAL encourages all staff and those who have active engagements with families to be proactive in identifying and reporting concerns of Domestic Abuse, the review feels that this process needs an element of protection and formalisation.

Recommendation 15. SHAL Housing should develop a policy to support a 'See something Say something' style of reporting by those in frontline services.

5.4.7.4 The panel noticed that during the period of their tenancy the only obvious area of concern was that of rent. David appeared to be responsible for paying the rent. There were periods where several thousands of pounds were outstanding. However, David seemed to be able to manage the situation following contact with the housing office. Sadly, the review panel will never understand the level of stress and strain this type of responsibility was having on David. However, as mentioned previously financial and housing worries has been identified as suicide triggers in the past[34] .

5.4.7.5 In June 2017 David attended the housing office to report the breakdown in his relationship with Tracey. During the conversation he made comments about Tracey neglecting the children but confirmed he had already spoken to the Children's Social Care offices. As a result, the Housing Officer decided not to investigate this matter. The IMR author and the review panel share the view that there was an opportunity here to be more professionally curious. Including sharing information with other agencies as this is likely to have triggered tenancy visits or similar engagement. Such visits would have provided a better understanding of how the family were being affected under these circumstances.

5.4.7.6 During an interview with the housing officers on the 31st July 2017 there were further opportunities for more professional curiosity. Specifically, regarding the risk to the joint tenancy which David had come to discuss. A more intrusive style of interview was likely to have resulted in further tenancy visits. Possibly uncovering a still clearer picture of the pressures and stresses that the family were facing.

5.4.7.7 Both of these subjects, Professional Curiosity and Information Sharing, have resulted in recommendations being proposed by Sedgemoor District council and are recorded in the recommendations section in Appendix Two below.

5.4.7.8 This review was anxious about the apparent financial difficulties which the family appeared to be facing. There was concern that these may have been a factor in causing David to decide to take his own life. These were discussed with the council and SHAL Housing and the review recognises the lengths that SHAL housings goes to, to prevent such evictions taking place.

Good Practice

Residents are provided support in identifying funding streams for those struggling to pay their rent, support during subsequent court processes and ultimately advice from homeless agencies in the event of final eviction. These were all processes which David and Tracey were offered during the period of this review.

5.4.7.9 As mentioned before one issue raised during discussions, with these agencies was that of Information Sharing. Particularly an apparent disconnect between agencies like SHAL, in being able to access pathways that would allow them to report and receive information about domestic abuse.

[34] https://www.mind.org.uk/information-support/types-of-mental-health-problems/suicidal-feelings/causes-of-suicidal-feelings/#CommonCausesOfSuicidalFeelings

Learning Point 17. Agencies like SHAL have, potentially, a good deal of contact with families suffering domestic abuse problems and the previous learning point encourages reporting of these matters. It appears to be a missed opportunity for the information, which they identify, not to be shared with other involved agencies. Similarly, there must be available information which could support SHAL et al in assisting families as well as allowing employees in assessing risk prior to making home visits.

Recommendation 16. The Somerset Domestic Abuse Board should review their information protocols in order that agencies like SHAL are able, to provide, and have access to, details from other agencies within the Community Safety Partnership.

Learning Point 18. SHAL recognises that there is a need for all agencies to take seriously the subject of professional curiosity. They report that prior to death of David there were reports to staff about problems in the home, including shouting and violence. There is a need to encourage staff to 'investigate' such reports, with their tenants, however, this should be done sensitively and with regards to suitable safeguarding guidelines.

Recommendation 17. Promote the availability of resources and training to improve understanding of "professional curiosity". To help ensure any reports and information that is provided to them are used to explore and understand what is happening within a family, rather than making assumptions or accepting things at face value.

5.4.8 Avon and Somerset Constabulary

5.4.8.1 Avon and Somerset had a total of 20 engagements during the review period, including 9 matters regarded as domestic incidents[35] and 4 matters interpreted as domestic violence including interfamilial cases involving David's sister Jill.

5.4.8.2 The death of David was treated as unexplained but not suspicious. As there had been previous, recent, contact between the deceased and the police, and in accordance with the statutory guidance of the Independent Office for Police Conduct – IOPC)[36] the case was reviewed by the Avon and Somerset Police Professional Standards Department. Their investigation found no cause or link between David's death and his involvement with the police and so no referral was made to the IOPC.

5.4.8.3 As with all domestic homicide review cases a significant cause of interest, particularly with regards to police and their initial investigation is the use of the DASH risk assessment. This conversation has taken place once again during this DHR. The panel has invited the police to confirm the methodology which they use in this area.

5.4.8.4 Prior to attending any incident Avon and Somerset police officers have access to internal crime and intelligence records (regarding previous incidents). Together with details of information that has previously been provided or recorded by police officers. Visual and oral evidence is recorded via Body Worn Video cameras.

[35] A domestic incident is a report where no crimes are alleged, disclosed or apparent, however a report is completed for recording purposes and to enhance the intelligence picture.

[36] https://www.policeconduct.gov.uk/investigations/our-investigations

5.4.8.5 The police confirmed that when attending reports of domestic abuse or violence attending officers complete an initial reporting template including a checklist for a DASH and BRAG[37]. This report is then sent via a 'task' to a first line manager. All reports are checked and reviewed by the Sergeant who completes the similar template. This document allows the Sergeant to confirm that previous domestic incidents and DASH risk assessments have been reviewed and checked to confirm that the latest risk assessment has been graded appropriately and if necessary, alter it. The review is also intended to check that safety issues have been raised to the LSU.

5.4.8.6 The panel recognises the calls to the police were primarily made from Tracey and were often of a low-level nature resulting in little or no required police action. The IMR author correctly identifies this as potentially being part of a coping strategy. These matters are often recorded as 'domestic incidents' and, as mentioned above, records are retained for information purposes and can provide potential intelligence leads during subsequent calls to the address or individuals.

Good Practice

Whilst analysing the various contacts with the police what is apparent is the officers routinely make referrals to what is recorded as 'Education, CSC and Health'. The chair is identified that these agencies form the Multi Agency Safeguarding Hub (MASH). The MASH is designed as a forum and pathway into differing agencies through a one front door process. The panel recognises that during previous review processes the use of the Multi Agency Safeguarding Hub (MASH) has been rather neglected. This review seeks to acknowledge an uplift in performance and recognise it as good practise, particularly from frontline staff and the LSU.

5.4.8.7 As mentioned above the issue of DASH risk assessing is worthy of mention at this stage in the report. As previously discussed, there were 13 domestic abuse type calls for police activity during the period of this review and it is noted that on eight of these occasions either a DASH risk assessment was not completed, or it is unclear to the IMR author whether one was completed or not. The occasions where no DASH risk assessment appears to have been completed could be summarised as being those also classified as 'domestic incidents', when no crime was alleged or identified.

Learning point 19. As mentioned above there is potentially an issue with officers failing to identify that all domestic abuse investigations, however small or apparently low-level, should have a DASH risk assessment completed during the initial stages. This will allow subsequent investigations to identify continuing concerns over risk.

"It's worth noting the MARAC process encourages referrals where has been 3 domestic abuse reports over 12 months[38]".

[37] Avon and Somerset Police continue to embed their BRAG risk assessment process within their ways of working. The BRAG tool prompts officers to think about how they address any aspect of vulnerability regardless of the level of risk. It allows officers to record what actions they think should happen in order to safeguard or protect any victim or person.

1. [38] It is common practice to start with 3 or more police callouts in a 12-month period, but this will need to be reviewed depending on local volume and level of police reporting.

The process outlined in paragraph 5.3.8.3 appears to provide a thorough understanding of the reporting and supervision of all domestic abuse matters. It may be the case that the weaknesses identified in this learning point have already been rectified however the panel seeks to be reassured that this is the case.

Recommendation 18. Avon & Somerset Police should ensure current procedures are promoted so that all staff are aware of the need to complete DASH risk assessment at the initial stage of all domestic abuse cases.

5.4.8.8 During the incident in February 2017 there was concern for David's mental health when police attended the family address following a call from Tracey. Whilst officers were at the scene David was able to speak to a Mental Health Triage nurse employed at the police headquarters.

Good Practice

David was given advice and guidance and an assessment was prepared directly afterwards. This is highlighted as good practice. Working in multi-agency settings like this allows for patients to receive reassurance and support and for the police and health care workers to work together in real time.

5.4.8.9 There are two other areas of interest to this review that have been subject to previous recommendations in other DHR's. In December 2016 there was an incident involving Tracey and Jill, whereby Jill was arrested for assaulting Tracey. During the investigation (both primary and secondary) no DASH risk assessment was ever completed. This review panel recognises this is a missed opportunity however will not be making any subsequent review recommendations for the reasons below.

<u>The previous recommendation on this subject stated:</u>
"Avon and Somerset Constabulary should work with its partners within the Community Safety Partnership and Bristol Safeguarding Children Board to review the effectiveness of its Domestic Abuse Risk Assessment model and investigative practice regarding non-intimate partner abuse."

<u>The following update has been provided.</u>
This issue was raised at the National DA meeting by our DA Theme Lead, Summer 2019. Avon and Somerset police were informed that several forces will be trialling a new DASH process. A decision to awaits as to the outcome of this trial as this will dictate the direction of the DASH.

5.4.8.10 The second issue here relates to the raising awareness of male victims of domestic abuse. There is a reported incident in this matter where David made a counter allegation that he, in fact, was the victim of an assault, for which he had been arrested. This allegation was not investigated, and no DASH risk assessment was ever completed. Once again, this subject has been dealt with during a previous DHR and a recommendation has been made. Therefore, no further recommendation will be completed other than to seek reassurance that progress has been made with the previous one.

https://safelives.org.uk/sites/default/files/resources/MARAC_FAQs_for%20MARAC%20practitioners_2013%20FINAL.pdf

The previous recommendation on this subject stated:
"The Force should take further steps to raise awareness of male victims of DA and make officers aware of their own possible unconscious biases in circumstances involving male victims. The Force should also undertake checking and testing to see whether male victims of DA are currently receiving expected standards of service by the Force".

The following update has been provided:
General unconscious bias training was rolled out between January 2017 and June 2018, initially aimed at Frontline Patrol and Neighbourhood officers (Including PCSO's). It has subsequently been rolled out in slightly different formats to Investigations, Communications, Specials, Custody and Intelligence (surveillance) members of staff. In total over 2000 staff have received this. Male victims of DA were not specifically covered in this training although we do cover victims that come in many different forms and run a case study to emphasise this. New Vulnerability training is currently being proposed and within this there will be a section on male victims of DA. This case study will be used to highlight potential unconscious biases, and this will meet the needs of the recommendation

5.4.8.11 The IMR author raises some concern about the performance of the officers on the day prior to David's death. Specifically, with regards to their understanding and training when dealing with subjects who have mental health issues, but do not fall within the criteria of section 136 of the Mental Health Act. The author proposes a recommendation that police control rooms should be able to use a prompt, or similar method, to remind officers of their powers, roles and responsibilities in similar circumstances. This review supports this proposal and details are enclosed in Appendix two.

5.4.8.12 There are various points or moments in time when during the police involvement with the family it could be argued that more professional curiosity could have been demonstrated. Also, better understanding of DASH risk assessments may have drawn out more detail, however there was never any evidence of any coercive control or restrictions in activities from either party.

Therefore, both had ample opportunity to make full disclosure of any domestic abuse which they were suffering. Hindsight will always identify opportunity and moments in time when things could have been done better. The points raised and recommendations made here are intended not to offer a critical eye but to seek to improve service.

6 CONCLUSIONS

6.1 CONCLUSIONS

6.1.1 David was a loving and caring father and a devoted family man. He worked hard to provide a home and loving environment in order that his family could develop and flourish. His death was a tragedy and affected all his family. It will impact on them for the rest of their lives.

6.1.2 For those close to David this tragedy is made more difficult because it appears to have been completely unexpected. Those closest to him knew that he'd had problems with his emotions and

had previously been diagnosed with depression. His relationship with Tracey was often challenging to the point where it broke down early in 2017. However, his loving devotion for his three children never wavered. David never ceased in his desire to bring them up in a caring environment. It was Tracey who reported that shortly after his death the two of them had rekindled their relationship with a view to re-establishing the family home.

6.1.3 There has been a challenge for the review panel to fully understand the nature of the relationship between David and Tracey, as they often sought to remain private when engaging with agencies in Somerset. One panel agency referred to their relationship with David and Tracey as being that of disguised compliance leading to ultimate avoidance ideology.

6.1.4 This appears to sum up things very neatly. Work done by the review panel members partly recognised there were times when agencies had opportunities to demonstrate more respectful uncertainty or professional curiosity when seeking to understand any challenges or issues the family faced.

6.1.5 The couple would use agencies, in Somerset, in what appeared to be part of a coping mechanism. For example, David would visit the GP in order to discuss his emotional vulnerability, and the stresses and strains he felt with home life. Reports to the police were mainly made by Tracey. However, these are often of a comparatively minor nature. Being referred to as police incidents, whereby no crimes were alleged or identified.

6.1.6 However ultimately, due to David's apparent emotional fragility he was offered a wide array of services in order to support him and his family. These opportunities for support included agencies such as the GP surgery, local hospital services, SHAL housing, and the police however, for reasons the tragically this review will never understand they were never seized upon.

6.1.7 As has been pointed out during this review, suicide is a human condition, and not a mental one and whilst there is no direct link between depression and mental illness, depression is often interpreted as a subcategory of mental health and this review has considered performance, where appropriate, through this lens.

6.1.8 The review panel considered whether there were periods, or moments, in time during this review where there were obvious triggers that should have warned professionals of his intention to take his own life. The panel is taking a holistic view in order to try to understand whether there were obvious failings which, had they been identified, could have saved David's life or diverted him away from this path.

6.1.9 Despite incidents whereby David collapsed, demonstrated evidence of self-harming, or discussed emotional lows the review cannot positively say that there were circumstances where had agencies acted in a different way this tragic outcome would have been averted. Having said that every review of this nature allows agencies to reflect upon their own performance, methodologies policies and procedures.

6.1.10 In approaching learning and recommendations, the review panel has sought to do two things. First, to try and understand what happened and consider the issues in the lives of David and, to an extent Tracey, that might help to explain the circumstances of the death. Secondly to use this case to

consider a wide range of issues locally including provisions for victims of domestic violence and abuse, both male and female.

6.1.11 The review panel wishes to extend its sympathies to all those affected by David death.

LEARNING POINTS

The following points of learning have been drawn out during various point of this review process. They highlighted throughout this Overview Report and drawn together here as a point of reference.

Learning Point 1. It is important that professionals have a better understanding of how to identify those likely to be at risk. Also what actions those professionals or local partnerships can take, to reduce the likelihood of future suicides, of this nature. Additionally a key purpose of DHR's is to reduce the likelihood of future cases like this. As the Home Office has access to all DHR's, as part of the quality Assurance process it can review learning across cases in a way that a single agency cannot.

Learning Point 2. The panel takes the view that there is an opportunity for the staff at the Musgrove Hospital Emergency Department to demonstrate more professional curiosity when dealing with victims of assault. David had disclosed to staff, that he had been pushed down the stairs at home. Also, there were concerns for David's mental well-being, raised by the ambulance crew upon arrival at the hospital.

Learning Point 3. The panel recognised there were opportunities here for David to receive potential support prior to leaving the hospital. For example, being provided with a leaflet explaining the role of the Psychiatric Liaison Team and to be provided with contact details for community support including mental health services.

Learning Point 4. There was an opportunity to make enquiries during a couple of consultations, such as when David alleged, he was pushed down the stairs. This is a learning point for the surgery about recognising someone, particularly a male who is experiencing Domestic Abuse.

Learning Point 5. Recent police reports should trigger routine enquiries about domestic circumstance and/or discussion with practice safeguarding lead and/or discussion in practice safeguarding/complex case meetings. If appropriate further enquiry's and possible onward referral e.g. to SIDAS Somerset Integrated Domestic Abuse Service.

Learning Point 6. A variety of effective interventions can make it easier for GP and NHS services to play their part in reducing domestic abuse and identifying the vulnerable. This should include access to training support and a referral programme in order to support them asking about and responding to domestic violence and abuse. This has already been implemented by the CCG over the past three years and is monitored through the annual safeguarding report that GP practices are required to return to the CCG. This annual safeguarding report includes information about Domestic Abuse.

Learning Point 7. The review recognises the principles of taking a holistic view when dealing assessments such as these. Professional curiosity is a skill that needs to be developed to seek every opportunity to understand the issues and challenges faced by all families in these circumstances. There were various missed opportunities here including the lack of interviews of the children 'independent' of their parents, the use of a DASH risk assessment and referrals to Somerset Independent Drug and Alcohol Service following disclosures about Tracey's use of controlled substances following her brother's death. There have been recommendations, made during previous local DHR's, with regards to professional curiosity and this review seeks to support them i.e. from DHR 022.

Learning Point 8. The review raises the issue of information sharing and this has been a subject of concern during many previous DHR's. It seems to be a crucial function of all assessments including Children and

Families processes, that those engaging with families have access to all reasonable pieces of information, and able to share it appropriately. This will often involve consent of the parents and be subject to all suitable safeguarding measures.

Learning Point 9. The review raises the issue of information sharing and this has been a subject of concern during many previous DHR's. It seems to be a crucial function of all assessments including Children and Families processes, that those engaging with families have access to all reasonable pieces of information, and able to share it appropriately. This will often involve consent of the parents and be subject to all suitable safeguarding measures.

Learning Point 10. An NSPCC fact sheet prepared in March 2010[39] gives some guidance in relation to disguised compliance, this involves a parental carer giving the appearance of cooperating with child welfare agencies to avoid raising suspicions to ally professional curiosity and ultimately to diffuse professional intervention. In the Victoria Climbié inquiry, Lord Laming (2003)[40] suggested social workers needed to practice "respectful uncertainty", applying critical evaluation to any Information they receive and maintaining an open mind. It appears that in both C&F assessments David and Tracey were keen to present their family in a light which would satisfy frontline staff that they weren't in need of any support or help.

Learning Point 11. In October 2019 the Somerset Safeguarding Children's Partnership produced guidance[41] for all those who work with children and families, contained within is a short reference in relation to disguised compliance. These details should be used to train frontline practitioners and managers about their responsibilities and the principles in managing situations where this is apparent.

Learning Point. 12 During their research the IMR the author identifies a lack of documented supervision and little in the way of strategy setting or support for the allocated social worker. There is a clear inference of missed opportunities at various stages in the reviews and these may have been more easily identified and resolved with regular focused documented professional discussions between frontline practitioner and supervisor.

Learning Point 13. The policy refers to the process to be followed in the event of attendance at an incident and why domestic abuse is believed to be a contributory factor. Based upon the details provided the panel seeks the following reassurances.

Learning point 14. Often domestic abuse incidents are as a consequence or have an outcome of violence and therefore perpetrators are reluctant to contact the police directly. Thus, ambulance services can be the first point of contact. Therefore, it seems reasonable that, where circumstances allow, efforts should be made to complete with a DASH risk assessment particularly if patients are removed from the scene of the incident and the injuries allow for this conversation to take place.

[39] https://lrsb.org.uk/uploads/nspcc-fact-sheet-disguised-compliance.pdf

[40] Laming, Lord, (2003) The Victoria Climbie inquiry: report of an inquiry by Lord Laming (PDF). Norwich: TSO P205.

[41]https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=10&ved=2ahUKEwibyomL2LXpAhWSSxUIHawpAzUQFjAJegQIAxAB&url=http%3A%2F%2Fwww.somerset.gov.uk%2FEasysiteWeb%2Fgetresource.axd%3FAssetID%3D62499%26type%3Dfull%26servicetype%3DAttachment&usg=AOvVaw20a7Uz_jqZ4Yfv6kmi5dS3

Learning Point 15. In order to support families and uplift SHAL's reputation as an agency who supports the reduction in domestic abuse the chair feels that it would benefit from formal Domestic Abuse accreditation.

Learning Point 16. SHAL encourages all staff and those who have active engagements with families to be proactive in identifying and reporting concerns of Domestic Abuse, the review feels that this process needs an element of protection and formalisation.

Learning Point 17. Agencies like SHAL have, potentially, a good deal of contact with families suffering domestic abuse problems and the previous learning point encourages reporting of these matters. It appears to be a missed opportunity for the information, which they identify, not to be shared with other involved agencies. Similarly, there must be available information which could support SHAL et al in assisting families as well as allowing employees in assessing risk prior to making home visits.

Learning Point 18. SHAL recognises that there is a need for all agencies to take seriously the subject of professional curiosity. They report that prior to death of David there were reports to staff about problems in the home, including shouting and violence. There is a need to encourage staff to 'investigate' such reports, with their tenants, however, this should be done sensitively and with regards to suitable safeguarding guidelines.

Learning point 19. As mentioned above there is potentially an issue with officers failing to identify that all domestic abuse investigations, however small or apparently low-level, should have a DASH risk assessment completed during the initial stages. This will allow subsequent investigations to identify continuing concerns over risk.

RECOMMENDATIONS

SINGLE AGENCY RECOMMENDATIONS

During the process of preparing their Individual Management Reviews. The reviewers/authors have been invited identify recommendations of their own. These are listed below.

Children's Social Care

1. Improve social workers ability to be more robust in the triangulation of information

Avon and Somerset Police

1. Avon and Somerset Police should consider how existing processes can be used to develop a prompt system that reminds officers of their training in relation to dealing with mental health crisis that does not meet these section 136 criteria and is not volatile potentially a reminder of tactical options available to manage a situation

SOMPAR, Taunton and Somerset NHS Foundation Trust

2. Improve knowledge of domestic abuse awareness in Emergency Department

Sedgemoor District Council

3. Strengthen housing options team's understanding of when to share information with social landlords (eg SHAL and similar) around risk to child neglect.

4. Strengthen housing options team's understanding of when to share information with social landlords (eg SHAL) and similar around risk to joint tenancy issues

Somerset NHS Foundation Trust

5. Improve consistency of community mental health staff always clearly documenting source of disclosure of historic domestic abuse relevant details, whether or not the information can be substantiated.

6. Change how Patient Liaison Team (with A&E) follow up to patients referred to the PLT but leave the hospital without being seen

SIDAS – Livewest

7. Improve the effectiveness and robustness of referral intake procedures within SIDAS

DHR PANEL RECOMMENDATIONS

Recommendation 1: Safer Somerset CSP to seek reassurance that training and Continuous Professional Development strategies reflect:

- Gender dynamics when dealing with incidents of domestic abuse.
- Identify 'triggers' associated with the escalation of domestic abuse.

Recommendation 2: The Safer Somerset Partnership to write to the Home Office with the findings of this DHR suggesting that they undertake further research into cases of suicide with a reported history of domestic abuse where the perpetrators are male, in order to develop a profile of potentially vulnerable men.

Recommendation 3: Home Office to undertake further research into male victims of domestic abuse in the BAME community and to raise awareness of referral pathways for all men who are victims of domestic violence.

Recommendation 4: Ensure that training packages are prepared and delivered in accordance with the guidance and directions provided within the SOMPAR DA policy.

Recommendation 5: Improve monitoring of reports to identify domestic abuse trigger's and, if appropriate, carry out further enquiries and possible onward referrals to GP Surgeries.

Recommendation 6: Safer Somerset Partnership in support with the Domestic Abuse Board to seek assurance in asking all agencies to provide evidence that they include professional curiosity in their safeguarding training.

Recommendation 7: Somerset Domestic Abuse Board to improve the effectiveness of relevant information sharing pathways in relation to domestic abuse and ensure that frontline staff are aware of the opportunities available to them and the ethical and legal ways all sharing information that they receive..

Recommendation 8: The CSC to reinforce the need for the interview of children in domestic abuse circumstances..

Recommendation 9: Improve the availability of training for frontline practitioners and managers about their responsibilities and the principles in managing situations where disguised compliance is apparent..

Recommendation 10: The CSC to improve governance protocols and if necessary, introduce a review framework that details, current risk and plans, going forward.

Recommendation 11: Reinforce the necessity to record contemporaneous notes at the scene of domestic abuse incidents and a referral is made to Trust Safeguarding Team within the 48-hour time scales which SWASFT policy requires.

Recommendation 12; Ensure that information sharing procedures are effective so that there's engagement with external and internal partners, whenever safeguarding issues are raised, in timely and proportionate manner.

Recommendation 13: SWASFT NHS Trust, to develop the training available to staff so that they are aware of how to complete DASH risk assessments

Recommendation 14: The CSP should consider providing funding to support SHAL and other housing providers bid to receive formal Domestic Abuse accreditation in order to raise its profile, provide reassurance to the vulnerable and discourage perpetrators.

Recommendation 15: SHAL Housing should develop a policy to support a 'See something Say something' style of reporting by those in frontline services.

Recommendation 16: The Somerset Domestic Abuse Board should review their information protocols in order that agencies like SHAL are able, to provide, and have access to, details from other agencies within the Community Safety Partnership.

Recommendation 17: SHAL Housing and similar housing providers to promote the availability of resources and training to improve understanding of "professional curiosity"

Recommendation 18: Avon & Somerset Police to ensure current procedures are promoted so that all staff are aware of the need to complete DASH risk assessment at the initial stage of all domestic abuse cases.

APPENDIX 1

Terms of Reference
Domestic Homicide Review (case 021)

1 Commissioner of the Domestic Homicide Review

1.1 The chair of the Safer Somerset Partnership has commissioned this review, following notification of the death of David in the county

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

1.3 The resources required for completing this review will be secured by the chair of the Safer Somerset Partnership.

2 Aims of Domestic Homicide Review Process

2.1 Establish what lessons are to be learned from this domestic abuse related death regarding the way in which local professionals and organisations work individually and together to safeguard people in similar circumstances to those of David.

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.

3 Timescale

3.1 Aim to complete a final overview report within 6 months (**tbc**) acknowledging that drafting the report will be dependent, to some extent, on the completion of individual management reviews to the

standard and timescale required by the independent chair. Additionally, the criminal justice process will impact on timescales so that key relatives and friends can be contacted for involvement without prejudicing the criminal proceedings, although the statutory guidance is clear a DHR should be commenced and concluded as soon as possible – and the Review Panel should be mindful of paragraphs 90 to 96 of the guidance.

4 Scope of the review

4.1 To review events up to the domestic abuse related death of David in September 2017.

4.2 Events should be reviewed by all agencies for 5 years (i.e. September 2012) preceding the domestic abuse related death. However, if any agencies have any information prior to that they feel is relevant, then this should also be included in any chronology/IMR.

4.3 To seek to fully involve the family, friends, and wider community within the review process.

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

4.5 Consider how (and if knowledge of) the risk factors surrounding domestic abuse are fully understood by professionals, and the local community – including family and friends, and how to maximise opportunities to intervene and signpost to support.

4.6 Determine if there were any barriers David faced in both reporting domestic abuse and accessing services. This should also be explored against the Equality Act 2010's protected characteristics.

4.7 To include any learning/information arising from the Community Rehabilitation Company's "Serious Further Offence Review" which is running in parallel.

4.8 Review relevant research and previous domestic homicide reviews (including those in Somerset) to help ensure that the Review and Overview Report can maximise opportunities for learning to help avoid similar deaths occurring in future.

5 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)

6 Domestic Homicide Review Panel

6.1 Membership of the panel will comprise:

Name	Agency
Peter Stride	Independent Chair and Overview Report Author
Mark Wolski	Co-Chair
Julia Burrows	Somerset Partnership & Taunton and Somerset NHS Foundation Trust.
Dr Andrew Tresidder	Somerset Clinical Commissioning Group
Roger Fawsett	Avon and Somerset Constabulary
Dave Baxter	Housing Health and Wellbeing, Sedgemoor District Council.
Heather Sparks	Taunton and Somerset NHS Foundation
Emma Martin	Children's Social Care
Leanne Tasker	Somerset Independent Domestic Abuse Service
Suzanne Harris	Somerset County Council Senior Commissioning Officer

The above was confirmed at the first DHR Review Panel Meeting held on 5 November 2018.

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

7 Liaison with Media

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

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

APPENDIX 2

Somerset Domestic Homicide Review 021 (David) – Action Plan – See separate document

APPENDIX 3

Glossary of Terms

AAFDA	Advocacy After Fatal Domestic Abuse
ASC	Adult Social Care
BRAG	Blue Red Amber Green Risk Assessment
C&F	Child and Family
CCG	Clinical Commissioning Group
CIN	Child In Need
CPD	Continuing Professional Development
CSC	Children's Social Care
CSP	Community Safety Partnership
CSW	Children's Social Workers
CT Scan	Computer Tomography Scan
DAL	Domestic Abuse Link worker
DASH	Domestic Abuse Stalking Harassment
DHR	Domestic Homicide Review
DVPO	Domestic Violence Protection Order
ED	Emergency Department
FIS	Family Intervention Service
GP	General Practitioner
IMR	Individual Management Reviews

IOPC	Independent Office for Police Conduct
LSU	Lighthouse Safeguarding Unit
MAPPA	Multi Agency Public Protection Arrangement Panel
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MDT	Multidisciplinary Team Meeting
NSPCC	National Society for the Prevention of Cruelty to Children
PFSA	Parent and Family Support Advisor
PHQ9	Patient Health Questionnaire
PLT	Psychiatric Liaison Team
SOMPAR	Somerset Partnership NHS Foundation Trust
SARSAS	Somerset and Avon Rape and Sexual Abuse Support service
SCU	Safeguarding Coordination Unit
SDC	Sedgemoor District Council
SHAL	SHAL Housing – community based provider of housing
SIDAS	Somerset Independent Domestic Abuse Service
SWASFT	South West Ambulance Service Foundation Trust
TST	Taunton and Somerset NHS Foundation Trust