OVERVIEW REPORT

of the

Domestic Homicide Review

relating to the unexpected death of Penny in 2019

on behalf of:

The Safer Somerset Partnership

Report Author: **Liz Cooper- Borthwick**

Independent Chair

Report submitted to Home Office: April 2021

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GLOSSARY

ABBREVIATION	DEFINITION
SSP	Safer Somerset Partnership
CSC	Somerset Children Social Care
SCCG	Somerset Clinical Commissioning Group
SIDAS	Somerset Integrated Domestic Abuse Service
SSDC	South Somerset District Council
BGSW CRC	Bristol, Gloucestershire Somerset and Wiltshire Community Rehabilitation Company (Probation)
Turning Point	Somerset Drug and Alcohol Service
KPE	Key Practice Episode
CMHT	Community Mental Health Team
CAMHS	Community and Adolescent Mental Health Service
LSU	Lighthouse Safeguarding Unit Lighthouse Victim Care
NTQ	Notice to Quit Accommodation
OIC	Police officer in charge of Investigation
EHA	Early Help Assessment
ELSA	Education Learning Support Assistant
SSDC	South Somerset District Council (SSDC)
IDVA	Independent Domestic Violence Advisor
TAC	Team around the Child
RO	Probation Responsible Officer
OA Course	Overcoming abuse course

FIW	Family Intervention Worker
ASC	Avon & Somerset Constabulary
UPW / RAR	Unpaid Work / Rehabilitation Activity Requirement
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub

1.0 PREFACE

1.1 This Domestic Homicide Review (DHR) examines agency responses and support given to Penny and her family before Penny's unexpected death in October 2019. The Safer Somerset Partnership determined that the criteria for a DHR had been met under DHR Statutory Guidance 2016, in particular paras 5(1), 18 and 27(c).[1]
The review will identify any agency involvement and will also seek to understand the family dynamics in the build up to Penny's death, whether support was accessed within the community, whether there are identified gaps in provision and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.2 DHR: Domestic Homicide Reviews became statutory under Section 9 of the Domestic Violence, Crime and Victims Act 2004 and came into force on 13 April 2011. The Act requires a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were either related, in an intimate personal relationship with or living with in the same household.

1.2.1 The Home Office defines domestic violence as:
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.
Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim'.

This 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.
This was expanded to include apparent suicides / unexpected deaths within abusive relationships in subsequent guidance. [2]

The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person died as a result of domestic violence and abuse. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each individual case and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

1.4 Time scales: The review began March 2020 and concluded with submission to the Home Office in April 2021.

[1] DHR-Statutory-Guidance-161206.pdf(publishing.service.gov.uk)
[2] Controlling or Coercive behaviour HO guidancehttps://www.gov.uk/government/publications/statutory-guidance-framework-controlling-or-coercive-behaviour-in-an-intimate-or-family-relationship

The DHR timeline was extended (with Home Office approval) due to impact of COVID-19; the ability for professionals to produce IMRs under these circumstances; additional time to allow the Independent Chair to seek further information from schools and other support agencies.

1.5 Incident summary: The purpose of this review is to examine the circumstances surrounding Penny's tragic death in **late October 2019** when she was found dead at her home.

1.6 Confidentiality: The detailed findings of each review are confidential. Information is available only to participating officers / professionals and their line managers. A confidentiality agreement has been signed at each meeting of the DHR Panel.

1.7 Dissemination: The Overview Report, Recommendations and Executive Summary have been redacted to ensure confidentiality, with pseudonyms used for the victim, children and family. The reports have been disseminated to the following groups:

i. Safer Somerset Partnership
ii. Somerset Safeguarding Adults Board
iii. Somerset Domestic Abuse Board
iv. Avon and Somerset Police Crime Commissioner
v. Somerset Safeguarding Children Partnership

2.0 DETAILS OF THE INCIDENT

2.1 The police received a 999 call from Mary in **late October 2019** who had found Penny dead, in her own home having appeared to have taken her own life. The police attended within 15 minutes of the call and assisted paramedics. The Police considered Penny's death to be non-suspicious. Penny's phone was submitted for analysis following a request from Penny's father around allegations that Tony (Penny's partner) had been harassing her in the days prior to her death. The police had no record of this harassment. The police examined the phone but there was no evidence of harassing calls by Tony to Penny.

2.2 **Post-mortem:** The post-mortem took place on **30 October 2019**. The cause of death was defined by the pathologist, but the DHR Panel made a decision not to include the full details in the report as the anonymity of Penny and the family could be compromised. Toxicology tests were conducted and detected Sertraline[3] in her blood which was consistent with therapeutic use and was a drug prescribed to Penny. There was also toxicological evidence that Penny had consumed alcohol at a level that in a normal social drinker would have been consistent with mild intoxication. The pathologist concluded however that "it is not possible to comment on the specific effects this may have had on the deceased, or her state of mind, at the time of death".

3.0 THE REVIEW

3.1 SIDAS (Livewest Housing - the provider of domestic abuse services for Somerset at the time of Penny's death) notified the Safer Somerset Partnership (SSP) of Penny's death on **5**

[3] Sertraline- an antidepressant used to treat major depressive disorders, panic disorder and obsessive-compulsive disorder.

November 2019. The SSP decided that the criteria for a DHR had been met and Liz Cooper-Borthwick was appointed as Independent Chair in March 2020.

3.2 The DHR was commissioned by SSP in accordance with the revised Statutory Guidance for the conduct of Domestic Homicide Review[4] published by the Home Office in March 2016.

4 TERMS OF REFERENCE

4.1 Terms of Reference were agreed by the DHR Panel in March 2020 and were regularly reviewed and amended as further details of events in Penny's life emerged. They are included in Appendix 2.

5. PARALLEL INVESTIGATIONS AND RELATED PROCESSES

5.1 Inquest

An inquest was held on 24 February 2020 which determined the cause of death (Please see paragraph 2.2).

6.0 PANEL MEMBERSHIP AND REPRESENTATIVES

The Panel consisted of senior representatives from the following agencies.

NAMED OFFICER	ORGANISATION	ROLE
Liz Cooper-Borthwick		Independent Chair
Suzanne Harris	Somerset County Council and Safer Somerset partnership	Senior Commissioning Officer (Interpersonal Violence) Somerset County Council
Andrew Sparks	Avon and Somerset Police	Detective Inspector
Katia Maggs	Somerset Children Social Care (CSC)	Child Protection Co-ordinator Somerset Children's Social Care
Melanie Munday	Somerset Clinical Commissioning Group	Deputy Designated Nurse Safeguarding Children
Peter Brandt	Bristol, Gloucestershire, Somerset &Wilshire Community rehabilitation Company	Assistant Chief Probation Officer
Heather Sparks	Somerset NHS Foundation Trust	Named Professional for Safeguarding Adults
Melanie Thomson	Live West (Housing Association) providing SIDAS until 2020	Safeguarding Lead

[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

Leanne Tasker and Katie Bielec	The You Trust -Providing SIDAS from 2020	Area Manager West
Tim Cook	South Somerset District Council	Locality Team Manager

The panel met 5 times during the period March 2020 to March 2021 (once face to face plus four virtual panel meetings).

6.1 Independence of Chair

The Chair and Author of the review is Liz Cooper- Borthwick, formerly Assistant Chief Executive at Spelthorne Borough Council in Surrey. Liz has a wide range of expertise including Services for Vulnerable Adults and Children, housing and domestic violence. She has conducted partnership Domestic Homicide Reviews for the Home Office and has attended Home Office Independent Chair training for DHRs and further DHR Chair training with Advocacy after Fatal Domestic Abuse (AAFDA). Liz has also been involved with several Serious Case Reviews. Liz has no connection with any of the agencies in this case.

7.0 SUBJECTS OF THE REVIEW

The main subjects of this review are:

DHR subject	**Age at death of Penny**
Penny **(Deceased victim of domestic abuse)**	**39 years old**
Tony **(Perpetrator of domestic abuse)**	**30 years old**
Sam **(Child of Penny)**	**16 years old**
Alex **(Child of Penny and Tony)**	**8 years old**

Significant others:

Subject	**Relationship**

Chris	Penny's previous partner and father of Sam
Mary	Penny's mother

8.0 METHODOLOGY

Contributors to the Review

8.1. Statutory and Voluntary Agencies:

Each involved agency submitted an Individual Management Review (IMR) in accordance with the statutory guidance. The agencies were asked to review their contact with Penny and the family for the period **I June 2011** up to the date of Penny's death in **autumn 2019**. This period reflected the period from when Penny was pregnant with Alex up until her death. Authors were independent of the incident and the reports were Quality Assured by the organisation. As the review progressed, additional agencies were identified who had contact with the family members and further information was requested. IMRs were received from:

i. Avon and Somerset Constabulary (the Police)
ii. Somerset Children Social Care (CSC)
iii. Somerset Clinical Commissioning Group (on behalf of the GP)
iv. Somerset NHS Foundation Trust (a letter, contact out of scope but relevant)
v. Somerset Integrated Domestic Abuse Service (SIDAS)
vi. South Somerset District Council (SSDC)
vii. Bristol, Gloucestershire Somerset and Wiltshire Community Rehabilitation Company (BGSW CRC)

The panel has given detailed consideration and professional challenge to the IMRs submitted by these agencies and the final documents have contributed significantly to this report.

8.2 Involvement of Family and Friends

The Independent Chair wrote to the family. Penny's father was the only person to respond and was genuinely concerned that a DHR was taking place. He stated he "knew nothing about such a review, and it brought everything back and the family were trying to move on". Penny's father did provide some information which helped to understand the personal background of Penny and her family. The family were updated by letter at key stages of the review but informed the Independent Chair that they did not wish to have any further contact including not reviewing the draft or receiving a copy of final report.

As the family did not wish to participate in this review, the pseudonyms used within this report were chosen by the DHR Panel.

8.3 Contact with Tony

The Independent Chair spoke with Tony who had been convicted of the offence of common assault and battery against Penny in **April 2019**. Tony was involved as he was a perpetrator of domestic abuse and the father of Alex.

8.4 Contact with the Children

Sam, Penny's child lived with Penny and Tony until March / April 2019 and then went to back to live with Chris (Father). Sam was written to via Chris about participating in the review.
Sam was nearly 18 years old and had witnessed domestic abuse between Penny and Tony and had been assaulted by Tony according to police records. There was no response from Sam's father or Sam.

The Panel considered whether it was appropriate to speak with Alex. Alex was young and evidence from the school indicated that Alex was traumatised by witnessing domestic abuse and having been allegedly assaulted by Penny. A decision was made not to make an approach to Alex. The school information provided a vivid picture of what Alex was experiencing whilst living in a home where Penny (mother), was experiencing domestic abuse.

8.5 Research and contacts by the Chair

8.5.1 The Chair made the following contacts to gather further insight into 'the voice' of the victim. Following receipt of the IMRs the Independent Chair spoke with the Head Teacher at Alex's primary school. The Head Teacher provided a significant amount of written documentation which has informed the facts, analysis and lessons learnt within the DHR report. Contact was also made with Sam's school and they provided additional information but stated that following Sam being excluded from the school the safeguarding records were forwarded to his new school. This school was also contacted but no information was received.

8.5.2 **Substance misuse** (alcohol) was identified as an issue within the IMRs and in the conversation with Tony. Tony admitted he was an alcoholic and said that Penny also was dependent on drink, although there was no evidence to support this. The IMRs stated that Penny did drink socially but she told a professional it was not excessive, and that she was not dependent on alcohol. The Independent Chair spoke with Somerset Drug and Alcohol Service (Turning Point) to understand what services were available to the local community and to understand the client profile in the local area. The Safeguarding Manager agreed to act as a critical friend to the DHR and reviewed the final draft report and made comments as required.

8.5.3 The Independent Chair also spoke with a representative from the Crown Prosecution Service to explore the requirements and use of restraining orders to protect victims of domestic abuse.

8.5.4 Penny needed housing as she was homeless following the break- up of her relationship with Tony. To explore present and future policies and procedures including new legislation within the Domestic Abuse Bill 2020, the Independent Chair interviewed relevant managers at South Somerset District Council.

8.5.5 **Mental Health** - Penny did suffer with her mental health and although she had very little interaction with Somerset NHS Foundation Trust, the named professional for Safeguarding Adults supported the review by overviewing the DHR overview report and providing constructive comments.

9. EQUALITIES

9.1 Penny was a heterosexual white British woman. Penny's relationship began with Tony around 2010 and the relationship ended in 2019.

9.2 Tony is a heterosexual white British man.

9.3 The nine protected characteristics of the Equality Act 2010 were considered (age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation). Only two of these characteristics is considered by the review to have had an impact – sex/gender and pregnancy. These characteristics are considered later within this report.

10.0 KEY PRACTICE EPISODES (KPEs):

Social Care Institute for Excellence (SCIE)-Learning Together [5]

10.1 Significant information has been made available for this review and the DHR Independent Chair has utilised the SCIE model "Learning together" to identify the key episodes in the lives of Penny, Tony, Sam and Alex in the lead up to Penny's unexpected death.

10.2 The Key Practice Episodes (KPE) are identified below and will be referred to throughout the report.

- **KPE One:** Penny's life before Tony
- **KPE Two:** Life with Tony and Penny's mental health
- **KPE Three:** Incident of Domestic Abuse
- **KPE Four:** Involvement with agencies
- **KPE Five:** Evidence of emotional abuse by Tony relating to custody of Alex.
- **KPE Six:** Death of Penny

11. OVERVIEW OF FAMILY LIFE

11.1 With the little information provided by the family, the overview of family life is taken from agency IMRs or contact with other agencies e.g. the primary school / secondary school. Penny had Sam with her partner Chris in 2003. There is evidence that Chris was involved with drugs and had spent time in prison. Penny suffered from anxiety and depression and twice took an overdose between the period of 2005-2006. IMRs indicate that Penny and Chris drank quite heavily.

Penny and Chris's relationship ended and she met another partner which ended in 2009. There was a report of Penny being a victim of domestic violence, receiving threatening phone calls. Penny met Tony around 2010 and Alex was born in 2012.

[5] https://www.scie.org.uk/children/learningtogether/

12. VOICE OF THE VICTIM *(based on information provided from notes written by Penny, the IMRs, contact with agencies and the brief discussions with family)*

12.1 Penny wrote notes about her feelings and issues that she was experiencing in 2019. The notes were found by her family and were provided to the police. Extracts from the notes have been included in the report to give Penny a voice.

12.2 Penny loved her children and wanted to try to do the best for them. During certain times in her life, she felt she was not supporting them enough, stating that "she felt she could not provide for them and felt worthless". Information provided by Sam and Alex's school said that Penny always engaged with the schools and supported the children's development.

12.3 Penny wrote in a note in July 2019 "*I hate my life at the moment, and now the icing on the cake is that it is really hurting my Mum and I am so sorry. My mum is a beautiful lady and if only I could be half of her, then maybe I could sleep and be proud of myself*".

12.4 Penny also said to the police how scared she was when Tony put his hands around her neck and later that "*Tony was doing her head in".*

12.5 Following the breakdown of the relationship between Penny and Tony, she was trying to do everything she could, finding accommodation, sorting out her finances, trying to resolve custody issues whilst still experiencing anxiety, depression and controlling behaviour from Tony.

13.0 THE FACTS

The below information has been drawn from a range of sources; the IMRs submitted by agencies (referenced where appropriate), and any information from family.

13.1 Key Practice Episode One – Penny's life before Tony

13.1.1 **From 2001**, Penny suffered from intermittent depression which was managed with fluoxetine, followed by citalopram and finally sertraline. In **2005**, Penny was referred to the Community Mental Health Team experiencing periods of depression and anxiety associated with relationship difficulties with Chris and low self- esteem.

13.1.2 A GP referral in **2005** stated that Penny had a long history of low mood for which she received counselling on several occasions. Following an overdose in **2006**, the GP referred Penny to the Community Mental Health Team (CMHT). The assessment by CMHT on **21 June 2006** indicated that Penny was having reoccurring problems with overspending, debt, drug and alcohol abuse which resulted in guilt and low moods. The GP mentions in their IMR about an historic letter in 2006 which mentioned an escalation of stresses over several months resulting in Penny taking an overdose. This was related to complex family dynamics and a turbulent relationship with Chris, Sam's father. *(Source CCG and SFT Trust IMR)*

13.1.3 **5 May 2009**, Penny visited the Housing Access Centre at South Somerset District Council (SSDC). She reported that she was escaping domestic violence outside Somerset and that she was currently staying with Sam's grandmother. The housing duty officer explained that the only emergency accommodation available would be in a Women's refuge, but that SSDC would consider assisting with a rent deposit to secure a private rented property. Mary (Penny's mother)

supported this but also said that there were many family connections in the area where she'd been living, and they felt Penny would be safer in this area.

13.1.6 The housing Duty Officer spoke with Next Step[6] and found a two-bedroom property in the area. Telephone numbers were given, and Penny was advised to take positive steps to close her old tenancy and to return 11 May 2009 for a follow up appointment.

13.1.7 **11 May 2009** Penny visited the Housing Access Centre and she confirmed she had seen the property and was going to take it. The landlord confirmed he was willing to offer Penny the tenancy. *(Source SSDC IMR)*

13.1.8 **25 June 2009**, Somerset Children Social Care (CSC) received a call from the police that Penny had ended her relationship with her partner at that time and that he had nowhere to go. There was an argument about his property. Penny and Chris had separated and therefore CSC felt there was no escalation of any abuse (Source *CSC IMR)*

13.1.9 **1 October 2009**, an incident was reported to the police which had occurred on **19 September 2009** where Penny's ex-partner had texted her about the ownership of some property. Penny had also received insinuating calls that he would burn Penny's house down. The police perception of the incident was that it was low risk *(Source CSC IMR).*

13.2 Key Practice Episode Two- Life with Tony and Penny's mental health

13.2.1 Around **2010**, Penny started a relationship with Tony.

13.2.2 **18 January 2011** Penny's landlord contacted her giving her two days' notice to leave as her rent direct debit had been "messed up" by the bank. Money had been taken from her bank account but had not reached Next Steps. The Case Officer (SSDC) advised Penny that the landlord needed to give two months written notice and that she should let her landlord know what had been happening. (*Source SSDC IMR).*

13.2.3 **28 January 2011**, Penny visited her GP with mild depression, but it was noted her mood was much more settled, she now had a job and agreed to consider starting to reduce the citalopram with a view to stopping.

13.2.4 **5 April 2011**, Penny visited the GP again with mild depression. She said she was concerned about Chris, and the access he had to seeing Sam. Chris was currently on probation for drugs. Sam was seeing the paternal grandparents for a weekend in four and the GP suggested that the grandparents supervised access to Sam's father when he is with them. *(Source CCG IMR).*

13.2.5 **20 July 2011** A Housing Case officer unsuccessfully tried to call Penny. The Housing Case Officer left a message asking Penny to contact them as they needed see the Notice to Quit (NTQ). The message confirmed that a new application was needed, and any outstanding debts needed to be repaid via a prepayment plan before further assistance would be provided to help with her rent arrears. *(Source SSDC IMR)*

[6] Next Step -Provider of Emergency Shelter in Somerset.

Later that day, Penny phoned back for advice as she was facing eviction. She reported that the notice was issued two months ago as she was in rent arrears. The Housing Officer advised Penny to take the NTQ to the local housing office as soon as possible.

13.2.6 **25 July 2011**, the Housing Advisor called Penny again but there was no answer.
another message was left advising that housing needed to see the original NTQ.
A note remained on the SSDC housing system stating that the recovery of outstanding money applied until 2015. *(Source SSDC IMR*)

13.2.7 In **January 2012** Alex was born.

13.2.8 **1 June 2012**, Penny visited her GP as she was starting to feel low again with a lack of energy and wanting to "run-away". She said she had no thoughts of self-harm or being harmful to the children. Penny told the GP she had family support and it was agreed to restart fluoxetine. She was warned about its potential side effects including suicidal ideation.

13.2.9 **2 July 2012**, Penny was seen by the GP. Her condition was not improving and she was reported to be still feeling extremely low, not coping, had a loss of appetite and weight and not sleeping well. Penny had a discussion to change to citalopram which she had in the past, it was agreed she would see the GP in two weeks and if needed increase the dosage. *(Source CCG IMR)*

13.2.10 **8 July 2016** Penny visited the GP again with symptoms of depression. Penny was still taking citalopram, but she felt she was stable, engaged and had two children to look after. The GP noted that "in the past when Penny tried to reduce her dosage, she was always worse, and that she may need to take citalopram long term". Penny and the GP discussed seeking support from Talking Therapies, and she was given the self- referral paperwork*. (Source CCG IMR)*

13.2.11 **31 March 2017** The police intelligence/safeguarding log showed that Sam had been exhibiting some concerning behaviour including writing the words kill and suicidal on Sam's hands. Sam's school and Penny facilitated access to a medical assessment and CSC were informed but they advised that Sam did not meet the CSC intervention threshold*. (Source Police IMR)*

13.2.12 **8 May 2017** Penny visited the GP and told the GP she had a lot on her plate, had no appetite, was worried about Sam who was going to Children and Adolescent Mental Health Services (CAMHS) [7] and she had a child aged 5. Tony was supportive but some days she struggled to get out of bed. Penny was given a Talking Therapies leaflet and the GP had a supportive chat with her about starting sertraline. It was agreed for a review in two weeks' time. *(Source CCG IMR)*

13.2.13 **24 May 2017**, Penny met with her GP, she said she was feeling better with a depression scale 6 out of 10. Penny said she had been sleeping well and enjoying things more. Penny stated that she had had a "lovely weekend with the kids on a farm". Her appetite was coming back, and she had no side effects from Sertraline. Again, the GP encouraged self-referral to Talking Therapies. *(Source CCG IMR)*

[7] Children and Adolescent Mental Health Service

13.2.14 **29 May 2018,** there was an incident between Sam and a friend during which a video emerged of Sam waving a knife around and Alex screaming. The police spoke with Penny and Tony and were satisfied that they would deal with this incident in an appropriate manner and that the knife was plastic. A CSC referral was made but no initial family assessment took place as the referral did not meet the required threshold. (*Source Police IMR)*

13.2.15 **22 July 2018** Sam was the victim of Actual Bodily Harm (ABH) by another youth. No action was taken but a common needs risk assessment was undertaken by the police and Sam declined any support. A social care referral was considered but not deemed appropriate.

13.3 Key Practice Episode Three- Incidents of Domestic Abuse- physical abuse by Tony

13.3.1 **3 March 2019,** Alex called 999 reporting that her parents were arguing. Officers attended the home and background checks were completed on Tony and Penny. Penny said that Tony was struggling with his alcohol consumption which placed pressure on the family, but she declined to complete a DASH. The officer completed a perceived[8] DASH which was rated as standard. Officers in attendance did consider a BRAG[9] but noted no vulnerabilities and that the family seemed well supported by a wider family network. Both children were linked on the Niche log (police recording system). The Lighthouse Safeguarding Unit (LSU)[10] reviewed the incident and made background checks and referrals were made to health and education in respect of the children (*Police IMR*).

13.3.2 **8 March 2019**, Alex's school was contacted by the Education Welfare service regarding the incident. This contact was part of the Domestic Abuse Schools Protocol[11] and the school was advised that Somerset Direct[12] had the information and would consider if CSC needed to carry out an assessment.

13.3.3 **24 March 2019** Penny phoned 999 reporting that Tony had twice put his hands around her throat. She said she was still able to breath but was very scared. A friend had to pull Tony off Penny and Tony was making serious threats against Sam although he was not present. Initially Penny did not want to support a prosecution, but Tony was arrested, charged and released on bail with conditions not to contact Penny. A Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment was completed and rated Medium noting high level of violence and that the perpetrator had a problem with alcohol which made his behaviour worse. A BRAG was completed and rated as green and stated that this was the second time in 22 days that police had attended, and that Tony was drunk. An LSU referral was made and referrals to health and education for Alex and Sam. Penny was offered Victim Support services from Lighthouse Safeguarding Unit (LSU)[13] and referred to domestic violence support with SIDAS.

[8] Ideally a DASH is completed with a victim, but if the victim declines, an officer completes a DASH based on knowledge they have ascertained. This is noted as a perceived DASH.
[9] BRAG -Vulnerability tool to help police officers to record risk and assess all forms of vulnerability and/or safeguarding. It is used along with a DASH to make officers more objective about someone's vulnerability and therefore level of risk. Ratings are Blue, Red, Amber and Green (Blue very high risk)
[10] Lighthouse Victim Care *https://www.lighthousevictimcare.org*
[11] Somerset County Council Domestic Abuse Schools Protocol, where SCC advise a school of any incident police are called to and a child was present.
[12] Somerset adult social care, children social care and public health services to check.
[13] LSU Lighthouse Safeguarding Unit Lighthouse Victim Care/About us

On discussion with Penny no referral was made to CSC as this was the first incident and Penny felt she could safeguard her children. (*Source Police IMR*)

13.3.4 The school agreed to see Penny the following day. Penny met with the Head Teacher and explained what had happened when Tony tried to strangle her, in front of Alex. Penny explained that Tony had been arrested and released to his mother's address. Penny detailed Sam's difficult behaviour, that Tony was stressed with renovating the house, that he drank a lot and was going to Alcoholic Anonymous (AA) meetings. The Head Teacher asked if anything like this had happened before and Penny said no. Penny also asked if Alex could have some help getting the homework done and this was agreed. When Alex was helped with the homework, Alex said to the Head Teacher "thank you for helping me. I could not do this at home as I fell out with my dad". On being asked why, Alex responded "he fell out with my Mum over Sam and strangled my Mum. He then got arrested".

13.4 Key Practice Episode Four- Agency Involvement with Penny and Tony following the reported Domestic abuse incidents.

13.4.1 Penny was referred to Somerset Integrated Domestic Abuse Service (SIDAS)[14] on **27 March 2019** by LSU with a DASH Score of 9. Below are some of the comments on the referral.

- Penny had been at work all day and came home to find Tony intoxicated. He started to accuse her of not cooking dinner and an argument started.
- The first time Tony assaulted Penny was in the kitchen; he grabbed her with his hands around her neck. Penny could breathe but was scared. Penny asked Tony to leave the house.
- 10 minutes later, Tony grabbed Penny around her neck in the living room. This was witnessed by a family friend who pulled Tony away from Penny.
- Alex was in the house at the time of the incident.
- Penny felt that everything had been triggered by the behaviour of Sam who threw a rock at Tony's rented vehicle. The relationship between Tony and Sam had deteriorated and now Sam had gone to live with Chris (father of Sam).
- Penny said that Tony had been saying he wanted to run Sam down with the van and punch and stop Sam breathing. The Safelives DASH score[15] was recorded as 9.

The referral was processed and allocated to a case worker.

13.4.2 **24 March 2019**, (but not reported until 22 June 2019) during a voluntary attendance by the police to Penny and Tony's home where Sam had caused criminal damage to Tony's work van. Sam made allegations that Tony had assaulted Sam three months earlier. Sam said that Tony had pushed Sam up against the wall and that although there were no injuries this was not the first assault and Sam had previously sustained injuries. After the initial allegation Sam did not engage further despite many attempts by the police and therefore no further action was taken. A BRAG was completed and rated as Amber (may be risk of significant harm). Referrals

[14] SIDAS – Somerset Integrated Domestic Abuse Service. Provided by Live West until end of March 2020.
[15] SafeLives DASH Risk checklist- a tool to identify high risk cases of domestic abuse, stalking and "honour" based violence.

were made to CSC for Sam and Alex with LSU support being offered to Sam via his father, Chris. *(Source Police IMR)*

13.4.3 During an Education Learning Support Advisor (ELSA) [16] check in with Alex on **29 March 2019**, Alex said, "I feel sad" and explained how "Dad had tried to strangle Mum". Alex also said, "*it had happened more than once, and Mum does not always tell the truth about what had happened with Dad"*. Alex asked for a 'feeling fan' so it could be used by Alex to express feelings.

13.4.4 Penny phoned the school on **1 April 2019** to say there had been another incident over the weekend and the Head Teacher invited Penny to meet on **3 April 2019**. Penny was very tearful and visibly shaking. She said she was under a lot of pressure from Tony's family to drop the charges against him relating to the domestic abuse. Penny admitted that it was not the first time Tony had assaulted her, and she was concerned if charges were dropped it would happen again. The Head Teacher asked Penny what support she had received from any professionals. She replied that she had a leaflet from LSU, and it was suggested by the Head Teacher that she contacted them as quickly as possible. The Head Teacher also suggested that Penny go to her GP, explain she was a victim of domestic abuse and that she was anxious and unable to sleep.

13.4.5 It was agreed that Alex would be supported through ELSA next term which would provide a safe place to share any feelings. Two days later Penny contacted the school to confirm that she was being supported by LSU and SIDAS.

13.4.6 ***Mid*-April 2019** Tony appeared before a Magistrates Court for the offence of Common Assault and Battery for the attack on Penny. He was sentenced to a Community Order-Offenders Rehabilitation Activity Requirement (ORA)[17] for a period of twelve months with the following requirement.

- Rehabilitation Activity Requirements -20 days
- Unpaid work - 80 hours

13.4.7 On the same day, the SIDAS Case worker contacted Penny for the first time. Penny requested some support and advised that Tony was in court that day and would plead guilty. Penny said she was staying with her mother and was not going to return to her home. The case worker asked Penny to consider requesting a Restraining Order to prevent Tony from contacting her and that if Tony wanted to see Alex this could be via a solicitor. The case worker discussed safety planning and advised Penny to download the Hollie Guard App[18] and call the police if needed.
Later that day the case worker contacted the Court staff and was advised that Tony had pleaded guilty. She updated Penny on the court sentence including that there was no restriction on Tony contacting Penny. The case worker again advised Penny to contact the police if he was abusive. *(Source SIDAS IMR)*

[16] ELSA: Education Learning Support Adviser
[17] ORA: Community Order-Offenders Rehabilitation Act – rehabilitation activity requirement
[18] Holly Guard App: smartphone app that provides enhanced levels of protection for safeguarding Hollie Guard Personal Safety APP

13.4.8 **23 April 2020**, Tony attended the group induction workshop at BGSW CRC (probation) where it was explained what was expected of Tony, which included.

- Understanding the role of the case manager
- What would happen if he did not keep to the terms of the Order?
- To learn about what support, services and courses were available to him.
- For him to start thinking about his goals

13.4.9 Tony was assessed late **April 2020** and was assigned a BRAG (Probation)[19] status of Amber. (Note this differs to the Police BRAG which indicates level of vulnerability). This identified that Tony needed a medium intensity of case management to assess and support his needs which included Tony being seen every 15-20 days by his Responsible Officer (RO).

13.4.10 On the **24 April** there was a planned meeting between the SIDAS case worker and Penny. Penny phoned the case worker to say she had thought the meeting was earlier and she needed to go out later in the day. The case worker said she could not manage to meet much earlier, so it was agreed to complete the paperwork over the phone.
A Safelives Dash Risk Identification Checklist (RIC)[20] was completed which scored 10 and formulated the Individual Support and Safety Plan[21]and Intake Form[22] which Penny agreed over the phone.

13.4.11 Penny said that the abuse from Tony had stopped but that when he came out of court, he was verbally abusive and aggressive to her, blaming her for losing his job.

13.4.12 Penny said she was contacting her solicitor regarding Tony's contact with Alex. Penny said she wanted to establish regular contact between Tony and Alex and wanted Alex to have a routine, but any overnight stays would be at Tony's mother's house. Penny said she thought Tony had not been drinking excessively since the incident and that he had started going to AA as part of his rehabilitation activity in the Community. She said she would be seeking housing advice from SSDC and register on Homefinder Somerset. Penny said that the abuse had escalated over the last three years and believed it was due to Tony's alcohol issues and the stress over his relationship with Sam. Penny said that Sam was moody and did not care if Tony had a mental breakdown. Penny said that they had taken on too much in refurbishing their new home with Tony taking everything out of every room and the house not now being habitable.

13.4.13 The case worker discussed safety again and advised Penny to contact the police if needed. The case worker asked Penny for details of Tony's mother's address and asked Penny to keep her updated about her contact with SSDC and any further abuse from Tony. *(Source SIDAS IMR)*

[19] BRAG Probation: The BRAG status for the Probation Service indicates the intensity of Case management undertaken with the service user. Red high intensity, green low intensity
[20] Safe Lives Dash risk checklist for the identification of high-risk cases of domestic abuse, stalking and honour-based violence for use by an IDVA (Independent Domestic Violence Advisers) and other non-police agencies www.safelives.org.uk
[21] Individual Support and Safety Plan for victims of abuse who are being supported by DV services.
[22] Intake Form- SIDAS procedure

13.4.14 **On 25 April 2019**, SIDAS noted that Penny's case was not being heard at Multi-Agency Risk Assessment Conference (MARAC) as the case had been through court and Penny had declined Independent Domestic Violence Advisor (IDVA) input.

13.4.15 **3 May 2019** Tony was assessed by his RO as posing a Medium Risk of Harm to the public, known adult and children within the community (a medium risk of harm means that the person has the potential to cause harm to others, but it is unlikely to happen unless there is a change in circumstances). The nature of the risk posed towards Penny (ex-partner and known adult) was assessed as being emotional and psychological harm through domestic abuse. The assessment also stated that the risk to the public was also that of emotional and psychological harm towards future partners. The nature of the risk posed to Sam and Alex was assessed as emotional should they witness domestic abuse.

13.4.16 On **5 May 2019,** the school noticed a bruise on Alex's arm. When the school asked Alex how she got it, Alex said it was from playing hide and seek and the arm got caught on something sharp. When asked if this is what really happened, Alex said yes, went red and looked at the floor. The Head Teacher phoned Penny about the bruise. Penny explained that Alex had been biting and sucking the arm and it was because Alex was worried. The school agreed to support Alex with coping strategies and the following points were discussed with Penny.

- Self-harm
- Making sure Alex does not overhear conversations between Penny and Tony and then decides what they mean.
- Working together to reinforce the strategies that Alex can use when worried or anxious.

13.4.17 **8 May 2019** Penny visited the Housing Department at SSDC saying she was staying with her mother due to the fact the property she owned with her ex-partner (Tony) was un-inhabitable. Penny explained that Tony was possibly going to have a Restraining Order placed against him due to violence. After obtaining advice from the housing specialist, the Customer Connect Officer explained that Penny would need evidence from Environmental Health that the property had been condemned or evidence that the police did not feel it was safe for her to reside at the address. *(Source SSDC IMR).*

13.4.18 **17 May 2019** A meeting took place at Mary's house with Penny and her SIDAS case worker. Penny said that Tony had been verbally aggressive to her when she told him she did not want him taking Alex to his new partner's home. Penny said that he was pointing his finger and swearing at her and said he could go where he wants when he has Alex although he did not make any threats towards Penny. She was advised to call the police if Tony did so and to keep contact with Tony to a minimum.

13.4.19 Penny said to her SIDAS worker that she was going to the SSDC offices that day and that she would take the letter from LSU as evidence of abuse and that she may also need a letter from SIDAS. Penny said that she would like to seek legal support regarding obtaining a Restraining Order and that she had met with a solicitor last year about an agreement regarding the deposit her father had given for the purchase of the property they bought. Penny said that once the house was sold then her father would get the deposit returned. Contact was made

with the Solicitor, who advised that no new Legal Aid clients were being taken but that the papers they had could be passed on to a new solicitor.

13.4.20 A meeting was arranged with a new solicitor about the property, including the financial settlement and child maintenance arrangements if Tony did not agree to pay Penny directly into her bank.
Mary advised that she would like a Bobby Van Service (BV)[23] referral completed.

13.4.21 **21 May 2019**, Tony attended an appointment with his RO and spoke about the incident between him and Penny. Tony minimised what happened saying "I just grabbed her, and it happened to be around the throat". Tony denied any previous domestic abuse against Penny or with any other partner. He said that their relationship was toxic and on the day of the incident they had been consuming alcohol which they did "to fill a gap, feeling they did not click".

13.4.22 On the **22 May 2019** Penny called the SIDAS case worker and said she could not attend the solicitor's appointment. The SIDAS case worker contacted the solicitor on **23 May 2019** to who said she had not heard from Penny but was willing to make another appointment.

13.4.23 The SIDAS case worker spoke with Penny on **24 May 2019**. Penny said she had been to a SSDC drop-in session and that the person she saw advised she needed a housing case worker and she would need to make an appointment to see one. Penny was upset as she was told she would need to arrange for an Environmental Health report to say the property was uninhabitable before they would help. Penny said she needed to apply again to Homefinder and that her letter from LSU was not sufficient. The SIDAS case worker asked who Penny had spoken to at SSDC but she said she did not know. She said she did give them a letter from her mother advising she had to leave in two weeks.

13.4.24 The SIDAS case worker said that she would send a supporting letter and that Penny needed to contact the Officer in Charge (OIC police) and ask them for a letter. The case worker asked how things had been since their last meeting and Penny said Tony was quite amicable and that she would like to meet the solicitor but would like support from the SIDAS case worker. The SIDAS case worker said she would arrange this.

13.4.25 Penny phoned the SIDAS case worker on **29 May 2019** and said she had spoken with a housing Officer at SSDC and that she was worried that she would have nowhere to go as the house was uninhabitable. The SIDAS case worker advised Penny to contact Environmental Health and establish when they could attend the property, to ask the police OIC to send a supporting letter and that she would contact SSDC to speak with the housing officer and discuss Penny's situation.

13.4.26 **30 May 2019**, the SIDAS case worker contacted SSDC Housing department and a housing officer confirmed what information/advice Penny had been given which was as follows.

- Needed to Submit a Homefinder Application
- Provide her Identity Documents (ID).
- A letter from her mother to state her two weeks' notice to leave.

[23] BV =Bobby Van Service now known as Be Home Safe scheme. A free home security service for vulnerable victims provided by Avon and Somerset police

- Evidence from Environmental Health that the property owned by Penny and Tony was uninhabitable.

13.4.27 The Housing department said that that the letter from LSU was quite vague and further information would be required from the police.
Penny confirmed that she had spoken with the OIC who would be sending a supporting letter to housing. The SIDAS case worker confirmed she would send a letter of support and that Penny said she would complete her Homefinder application.

13.4.28 Penny and the SIDAS case worker met the solicitor on **5 June 2019** and the solicitor went through Penny's options.

- Penny to consider whether she wanted a warning letter sent to Tony.
- For Legal Aid she would need an IDVA letter.

*13.4.2*9 On the same day, Penny had a consultation with the nurse practitioner at the GP practice. Penny had symptoms of depression and told the nurse practitioner that she had recently split from Tony, Sam, her child was living with his birth father, Alex, her other child was with her and she was unable to live in the family home. It was joint owned with Tony and was uninhabitable. Penny explained she was living with her mother, she had no thoughts of self-harm or suicide although she was struggling to see a way forward, and not eating or sleeping well. She recently started a new job, so she did not want to take time off. Penny's Sertraline dosage was increased and again she was given self–referral information for Talking Therapies.

13.4.30 **7 June 2019**. Penny called into the Housing Access Centre with a letter from LSU Victim and Witness Care dated 17 April 2019. This was triaged by the housing team and Penny presented as homeless and experiencing domestic violence. Penny did not have time to complete the H-clic[24] and arranged to return the following Monday to be triaged and see the duty officer with a view to securing temporary accommodation. She was also asked to start completing a Somerset Homefinder application and to bring identification. Penny was advised that the temporary accommodation would be a shared unit in Yeovil or a in a bed and breakfast. *(Source SSDC IMR).*

13.4.31 **13 June 2019** Penny advised the SIDAS case worker that she had spoken with the school and was concerned about Alex's behaviour. She said that Alex had hit and sworn at her. Penny said that Alex was angry with her and that the school were supporting Alex with an ELSA[25]. The SIDAS worker said she was happy to speak with the school and discuss whether they felt an EHA[26] was needed to get support from CSC or GET SET Services[27] depending on what Alex required. Penny said Tony had not been abusive to her, but he was not happy about the solicitor letter about access to Alex. The SIDAS case worker advised Penny that she may need to consider regular child contact for Alex as children like routine and that this may have affected her behaviour.

[24] H-Clic: Homelessness Case Level Collection
[25] ELSA: Education Learning Support Advisor
[26] EHA: Early Help Assessment
[27] Get Set Services: Somerset Services providing support to families who need a little extra help. Now known as the Family Intervention Service

13.4.32 Penny advised the SIDAS case worker that the solicitor had also written to Tony about her returning to the house as she could not stay with her mother any longer. Penny said she was going to visit their house the next day to see how habitable the house was. Penny explained that SSDC had confirmed that she could complete a homelessness application, but that would be for temporary accommodation in bed and breakfast, not in the present area and she felt this would upset Alex further.
Penny had told Tony and he said that "You can go into bed and breakfast and Alex can live with me". *(Example of emotional abuse by Tony)*

13.4.33 The SIDAS case worker discussed a safety plan for Penny returning home and Tony doing some of the work. It was suggested that Penny discussed this situation with the solicitor to see what legal measure may be required.
The solicitor contacted the SIDAS case worker and said she needed an IDVA letter to support Penny's legal aid application. *(Source SIDAS IMR)*

13.4.34 Mary took Alex to school and explained to the Head Teacher that Penny was struggling with Alex's behaviour at home. Alex hit out at Penny who was trying to tie Alex's hair up. Alex wanted to go to Breakfast Club, but Penny could not always afford it. The Head Teacher printed a leaflet about SIDAS and the support that may be offered. Penny came to school to collect the information and said she was going to take Alex out of school, but the Head Teacher advised against this as Alex needed routine. The Head Teacher asked Penny if she had pulled Alex's hair. She confirmed that she had but she had not 'yanked' it.

13.4.35 Later that day Alex met with her ELSA and they discussed Alex "playing up" - Alex's words. It was explained that if Alex felt angry the following options may help;

- Use breathing techniques learnt to calm down.
- Talk to find a safe way to resolve the problem.

Alex stated that the anger was from "not seeing Dad as much as wanted".

13.4.36 On the same day the Head Teacher phoned SIDAS and it was confirmed that Penny had an IDVA[28]

13.4.37 **18 June 2019**, Tony had a further meeting with his RO about the unpaid work requirements he needed to do as part of his sentence. Tony went on to say that he was having contact with Alex 2-3 times per week and on most weekends and that Penny was being more co-operative, however he had come to the decision that they needed to sell the house as he was unable to afford it on his own.

13.4.38 Alex met the ELSA in the playground and said that 'Dad has a new girlfriend and that she was nice'. Alex also said that her father had been seeing someone else whilst still with Penny. Alex took a photo of Penny fighting with this other person and showed it to Tony. Tony then broke up with the other person.

13.4.39 **19 June 2019**. Penny advised the case worker that she had not suffered any further abuse from Tony but stated he was nice one minute and verbally nasty the next, telling her the

[28] IDVA: Independent Domestic Violence Adviser

house needed to be sold. Penny said she felt that Alex was very confused as Tony was taking Alex to his new partner's house. Penny said that Alex had said that to her", I saw Tony drinking and had heard from other people he was dealing drugs". Penny felt Tony was 'screwing up' Alex's head. The case worker advised Penny to speak with her solicitor about this.

13.4.40 Penny mentioned that she was thinking of moving back to the house at the weekend and the SIDAS case worker advised Penny to speak with the solicitor as a Civil Order may need to be in place. Penny said Tony agreed with her moving back in, but some further work on the house was needed. The SIDAS case worker asked Penny how she would feel about Tony letting himself in. Penny said she would be frightened, and she would discuss with the solicitor about getting a Civil Order in place.

13.4.41 Penny was helping the school walk the children to swimming and she spoke with one of the teachers saying she was not happy that Tony had introduced Alex to his new girlfriend. Alex was asking "will this be my stepmother? will they get married?"

13.4.42 **20 June 2019**, the Head teacher at Alex's school contacted the SIDAS case worker with Penny's permission. The Head teacher explained that Alex was supported by the ELSA and nurturing staff, but it was felt that Alex needed more specialist help. The Head Teacher said that Alex's behaviour had deteriorated since they started living with her grandmother, Mary.

13.4.43 It was highlighted that Alex had been biting and sucking arms and there was a discussion about self-harm and not overhearing the conversations about what was happening to Penny. The Head Teacher disclosed that the school had been given information that Penny was out socialising and drinking (which she was entitled to do). The Head Teacher also said that Mary had told them about Alex swearing at and hitting Penny and that Alex was worried about not seeing Tony.

13.4.44 The SIDAS case worker asked if the Head Teacher had completed an Early Health Assessment[29] and she said that the school did not feel the situation would meet the threshold required for Level 4 support but that she would speak with Penny about a referral. The SIDAS case worker asked if a TAC[30] approach would work and the Head Teacher said she would investigate this?

13.4.45 **25 June 2019,** CSC received contact from the police that Sam had alleged that Tony had assaulted Sam on more than one occasion. CSC evaluated the risks and as the matter continued to be investigated by the police, Sam was now living with Chris (the father) and education professional had raised no concerns, therefore there was no role for CSC at this time. *(Source CSC IMR).*

13.4.46 **29 June 2019** Tony's Responsible Officer (RO) received a call that Tony was unable to attend his unpaid work that day as Alex had been "dumped on him" and he could not get anyone to look after Alex.

[29] EHA-Early Help assessment -assessment which captures a child /young persons and family needs at an early opportunity.
[30] TAC- Team around the Child- Bringing together of different agencies into one meeting where there is a concern about a child or family within a common assessment framework.

13.4.47 **11 July 2019,** Penny advised the SIDAS case worker that she had decided not to return to the family home and to continue to live with her mother. Penny said that Tony was completing the renovation and then the house would be sold. Penny asked if the SIDAS case worker would visit SSDC with her regarding accommodation as her mother needed her to leave*. (Source SIDAS IMR). (Example of economic abuse as Tony was dictating the financial situation which was impacting on Penny's living arrangements).*

13.4.48 **16 July 2019** Tony had another meeting with his RO and said he was unable to attend unpaid work until 10 August as he had a holiday (which had been approved) and he had paid work and needed to look after Alex. Tony spoke about childcare; (he said he had had Alex for 8 nights), the house and the bills were causing him a lot of stress. *(Source BGSW CRC IMR).*

13.5 Key Practice Episode Five - Escalation of emotional abuse by Tony around custody of Alex.

13.5.1 **1 August 2019**, Penny advised the SIDAS case worker that the situation between her and Tony was deteriorating and that he had told her mother that she was not right in the head and that he was going to court to get custody of Alex. Penny said she was speaking to her solicitor as she did not want this to happen. Penny said that Tony had told her she would get no proceeds from the house as she owed him £8500 but Tony had not paid child maintenance. Penny was advised to inform her solicitor of the situation. *(A further example of economic abuse by Tony).*

13.5.2 **8 August 2019** Penny and the SIDAS case worker met with the SSDC Housing Officer. The officer apologised that if Penny had been told she could not be helped that was not the case. Penny outlined her situation and the Housing Officer advised that she needed to complete another Homefinder application as the previous one was closed as no supporting evidence was provided. Penny asked the SIDAS case worker to help her fill in a new application as she had struggled last time. Penny was advised that she needed to complete an income and expenditure form and send 8 weeks of bank statements. The SIDAS case worker helped Penny fill in the Homefinder form and scanned her Identity Details (ID) into the document.

13.5.3 Penny said that Tony was continuing to harass her over child contact with Alex although she had not gone to the police. When he collected Alex, he had said "what a useless mother she was" telling Mary not to leave her alone with Alex as she was not capable of looking after the child. Penny said, "he messes with my head".
Penny advised she would like to attend an Overcoming Abuse[31] course and complete a FIW[32] referral as she is struggling with Alex's behaviour.

13.5.4 **13 August 2019** Penny informed her SIDAS case worker that she has been offered a property and that she would be contacting her solicitor about her application for Legal Aid. She said that Tony had texted her saying she was an unfit mother and that he was going for custody of Alex. The SIDAS case worker advised Penny to speak with her solicitor.

[31] O/A -Overcoming Abuse
[32] FIW - Family Intervention Worker

13.5.5 **14 August 2019**, Penny phoned the SSDC Housing department regarding a rent bond. The housing officer advised Penny to bring in a bank statement, payslip, and the income and expenditure sheet she had already been given. A meeting was arranged for the following week as the rent was above the Local Housing Allowance (LHA).

13.5.6 **20 August 2019,** Tony failed to attend his scheduled appointment with his RO. He phoned from work, apologised to the RO and said he had been so busy getting the house ready for a sale and looking after Alex a lot.

13.5.7 **4 September 2019** Penny visited the Housing Office hoping to apply for the rent bond scheme as she had found a property to rent. As the rent was above the Local Housing Allowance, she was advised that she was not eligible for the bond scheme. If she chose to proceed then later, if she were unable to pay her rent, she would be classed as intentionally homeless. Penny stated that she had tried to find cheaper properties and that staying with her mother was causing stress for them both. Penny said she was not sure if she wanted to proceed with the new tenancy as she had no funds. Penny said that Tony had told her that the selling of the house was nothing to do with her. The SIDAS case worker told Penny to inform her solicitor. *(Source SIDAS and SSDC IMR) (Example of economic abuse by Tony)*

13.5.8 **5 September 2019**. The SIDAS case worker completed a FIW referral. Penny also contacted her SIDAS case worker and explained the situation about her new home and asked if any other agency could help. The case worker suggested contacting the Citizens Advice Bureau. Penny said she had not completed her budgeting form, so the SIDAS case worker advised her to ask to confirm when she completes the form.

13.5.9 **16 September 2019**, The Head Teacher closed the specific case for concern file on Alex, but the family situation continued to be monitored by the school . On returning to school after the summer holidays Alex was eating well and had settled into the new class.

13.5.10 **17 September 2019** Tony met again with his RO. He reported that Penny was in the process of moving her belongings out. He said he hoped the house would sell quickly and that he was looking to rent in a village which he had friends and that he liked village life. Tony told the RO that Penny prioritised her social life and finances over spending time with Alex and he was willing to have Alex full time as he feels he can give Alex the attention she needs. Tony said he had a supportive boss who understood childcare commitments and that he had started a new relationship having told his partner about his offence and probation involvement. The RO recorded that he thought Tony looked well and was accepting of his situation *(Source BGSW CRC IMR).*

13.5.11 **24 September 2019**, the SIDAS case officer spoke with Penny (there had been several texts and missed calls between 6 - 24 September). Penny said she had moved into her new home and that she would like to meet to discuss her situation. Penny asked if the case worker had spoken with the Head Teacher at Alex's school. It was explained that another officer at SIDAS had been trying to contact the school as they would be better placed to support the FIW referral.

13.5.12 On the same day, Tony went to Alex's school to discuss behaviour changes he had noticed in Alex. He said Alex missed school yesterday due to being very emotional that morning, wanting to go to school with his current girlfriend. He said he wanted Alex to live with him as he thought there would be more routine, and he did not believe that Alex was getting on with Penny. The school thought Alex was responding well in school and had seen no change.

13.5.13 The Head Teacher phoned Penny about this disclosure. Penny said Tony was filling Alex's head with nonsense about her. Alex was confused about who is there during the week but not at the weekends. Alex stayed at Tony's at the weekend and he refused to bring Alex home. Penny explained that she had moved out of the family home but that she was named on the mortgage. Penny was reminded about Alex's school attendance which was good Weds - Fridays but poor on Monday and Tuesday.

Penny said she needed to speak with her IDVA at SIDAS about an injunction relating to Tony. The Head Teacher explained that she needed the ability to speak with both parents as they currently had joint parenting responsibilities. Penny asked that Tony should not be spoken to until after her conversation with the IDVA.
The Head Teacher explained that she had been told that Penny had turned up on Sunday night at Tony's house, banged on the door and kicked his car. Penny said that this was ages ago, but the Head Teacher explained that Alex was obviously struggling with everything and the adult behaviour was not in Alex's best interest.

Later that day the Head Teacher phoned Penny and said that with all the information she felt that a Team Around the Child (TAC) meeting should now take place. It was explained that Penny would invite her mother Mary and the SIDAS case worker would also be invited. Normally both parents would be invited but due to the situation with Tony it was agreed that only Penny would attend.

13.5.14 **25 September 2019** Alex's grandmother Mary approached the school about an outburst from Alex before coming to school. The teacher spoke with Alex and it was disclosed that when Alex went to bed, male voices could be heard downstairs, Alex did not know these men, but they were nice. Alex also said Mum often got drunk in the evening which Alex stated was not good. Alex had asked Penny to see her dad and was told "no he is a bitch". Alex responded by saying no and stomped upstairs. Alex also said that Mummy's boyfriend shouted at her.

13.5.15 **28 September 2019** A 999 call was received from Penny requesting immediate police attendance. Tony had turned up at her house demanding to see Alex and he was verbally abusive to Penny. The police attended Penny's home and the call was cross referenced to a previous incident and background checks were completed. The incident was referred to the LSU and consequently reviewed at the Somerset Domestic Abuse Triage (DAT) meeting. A DASH was completed and rated as Standard. A BRAG was completed and rated as Green, noting that domestic incidents were happening in front of the children, but that Penny was getting support from SIDAS and had been given advice about dealing with incidents. (*Source Police IMR)*

13.5.16 **30 September 2019**, the SIDAS case worker received a further referral from LSU for Penny where Tony had turned up at the home address demanding to see Alex and was verbally

abusive to Penny. Penny blocked his number so Tony could not contact her. *(Source SIDAS IMR)*

13.5.17 The Head Teacher met again with Penny regarding the concerns raised by Alex earlier. Penny said she was on prescribed painkillers for her back and was staying with her mother as she was a bit spaced out on the medication. The incident when Penny's boyfriend shouted at Alex was discussed. Penny said it did happen but that the person was not a boyfriend. Penny was challenged about her drinking, as she had been on several occasions by the school. She said she had a couple of drinks a night but was not drunk. The Head Teacher explained that Alex was very vulnerable and seeing Penny drink was not a good outcome. Support was offered to Penny relating to alcohol, but it was declined. Penny did say she understood that the situation was not good for Alex.

13.5.18 **1 October 2019** Alex went to a teacher and claimed that Tony had come to Penny's house banging on the door and that Penny had rung the police. Alex said that he had bought a new smaller van which Alex thought was easier to hide from the police compared to the last van. Alex said, "I went out to play and Dad chased after me - it was like being robbed". Penny also told SIDAS of this incident on **2 October 2019.**

13.5.19 **3 October 2019** The TAC meeting was cancelled as not all agencies could attend. The school took the opportunity to meet with Penny. Penny told the Head Teacher that she and Alex had moved into a new home and they were staying there after a short stay at her mother Mary's house. Penny explained that she was on strong pain killers for her back that made her feel drowsy and therefore she and Alex had stayed at Mary's to ensure there was another adult around to ensure Alex's safety and wellbeing. Penny said that Alex would like to see more of Tony, but she was afraid of the threats he had made about not bringing Alex back and saying to Alex that she was a bad mother.

13.5.20 **4 October 2019** Penny contacted the SIDAS case worker, and said she was keen to move forward with the FIW referral and that Alex was not currently having contact with her father.

13.5.21 **10 October 2019**, a phone call took place between Barnardo's, the Family Intervention Children's service manager and the SIDAS case worker about the FIW consultation. Penny also spoke with the SIDAS case worker that day stating that she was now allowing Alex to see Tony as Alex was missing him. Penny was worried that he would not return Alex. Penny was advised to contact the police if this happened. Penny texted the case worker again and said that Tony had brought Alex back but then Alex returned to his home again with Penny agreeing he could keep Alex for up to 25 days.

13.5.22 **14 October 2019,** Penny asked the SIDAS case worker for support at a meeting with her new solicitor, but the case worker could not attend. Instead, the case worker sent a letter to the solicitor in support.

13.5.23 **15 October 2019**, Penny contacted the SIDAS case worker to say she had arrived at the solicitors and reported she could not afford the rent and that she did not know what to do and housing benefits would not be able to help until next month*. (Example of economic abuse as Tony was controlling the house sale which impacted on Penny).*

13.5.24 **17 October 2019**, Tony went to see the RO (unplanned) to apologise for missing his last meeting. The RO and Tony discussed the completion of the unpaid work as he had been offered paid work over the weekends for the next couple of months and he needed the money. The RO agreed that Tony could take the paid work but that he must keep in touch so his records could be updated. Tony said he could take a week off work to complete his unpaid work, but the RO advised he should complete his hours over the weekend. Tony told the RO that the house was on the market and that Penny had stopped him seeing Alex for no apparent reason. Tony had consulted a solicitor and was now seeking a formal arrangement. Penny has since offered him contact but he is still proceeding with legal action (*Source BGSW CRC IMR)*.

13.5.25 **24 October 2019** A 101 call was received from Tony reporting that Alex had called him from Penny's house claiming an assault by Penny. Tony reported that when he went to pick up Alex that Penny was very intoxicated. Alex had no visible or confirmed injuries. The call handler ascertained that there were no immediate safeguarding actions to be taken and it was agreed that Alex could remain with Tony overnight. Tony was called first thing in the morning, a BRAG was completed and rated as Green. The police considered suitable lines of enquiries including liaison with CSC, interview with the male present at Penny's house and if appropriate to conduct an Achieving Best Evidence (ABE) interview with Alex (the victim). LSU referred the incident to the DAT meeting on 29 October 2019 which would be attended by CSC and SIDAS. Referrals for Alex were made to health and education. *(Source police IMR)*

13.5.26 The school received a call from Tony explaining there had been an incident with Penny and Alex and that Penny should not collect Alex after school.

13.5.27 **24 October 2019**, Barnardo's contacted Penny by text for the FIW case worker to introduce herself and confirm the meeting on **25 October 2019**. Penny confirmed that was fine.

13.6 Key Practice Episode Six - Death of Penny.

13.6.1 **Late October 2019 a** 999 call was received from Mary who had found her daughter Penny dead.

14 ENGAGEMENT WITH OTHER AGENCIES AND IMR FEEDBACK

This section has been compiled from the Individual Management Reviews (IMRs) submitted by the agencies involved in this case. The IMRs aimed to provide an accurate account of an agency's involvement with Penny, Tony, Sam and Alex up until the date of Penny's death. All IMRs have been challenged robustly by the panel and, where appropriate, have been subject to review and revision.

Some IMR comments have been included under the relevant KPEs in the main body of the report, to provide a clearer, chronological overview. Where this is the case, the IMR source is clearly referenced.

14.1 Avon and Somerset Police IMR

14.1.1 Avon and Somerset Police (the police) recorded four incidents with Penny and the family prior to 2012 and a further six incidents relating to the DHR timeline. The six later incidents

related to domestic abuse (3), incidents with Penny's children (2) and the final contact relating to Penny's death.

14.1.2 The IMR author noted that appropriate action, including safeguarding, was taken in relation to the 6 incidents with police involvement. DASH and BRAG were completed in line with standard practice. Where appropriate the incident was discussed at DAT with CSC, health and education.
The response times to all the incidents and the 999 calls were quick and in accordance with the Threat Harm Risk (THR) matrix. The IMR author noted that there was a good level of supervision, that all incidents were logged and recorded as per ASC's[33] Crime and Incident Recording Procedures, which are in line with the Home Office Counting Rules (HOCR) and the National Crime Recording Standards (NCRS).

14.1.3 All three incidents of domestic violence were fully investigated, and a DASH was completed in every instance. Penny was consistently referred to LSU for victim support and safeguarding.

14.1.4 There was support and intervention for the children with CSC being at the DAT meetings. Sam and Alex were linked on Niche for every incident (apart from one). Following the incident on 24 October 2019 where Penny allegedly hit Alex, a Niche for the incident was updated on 4 November 2019 and the incident closed following Penny's death. The IMR author noted that Sam was not linked on the Niche log and there was no record of any safeguarding considerations for Sam. Although Sam was not living with Penny at the time of the incident, Sam was still a relevant child. Due to Penny's death an investigation into the incident did not take place however Sam could have been identified as a relevant child by the OIC or LSU. No recommendation was made about linking relevant children as the investigation did not get underway before Penny's death and Sam was not living with Penny at the time of the incident. It was determined therefore that the OIC did not fail to safeguard Sam.

14.1.5 A DAT pilot commenced in September 2019 and there were daily meetings involving Police, CSC, SIDAS, Somerset Partnership NHS Trust and the local authority Education Safeguarding Service. Its purpose was to triage incidents of domestic abuse involving children that the police had received in the proceeding 24 hours. The aim of the DAT was to perform an assessment as to which agencies required a Police report in respect of the domestic abuse incident; the outcome of the DAT was recorded by the Police. The alleged incident between Penny and Alex was planned to have been discussed but Penny died before this happened.

14.1.6 The DAT is not now in operation and is considered later in this report in paragraph 15.3.44.

14.1.7 Lessons Identified:
The author of the IMR stated that, with hindsight there may have been a different outcome for Penny had a different response been taken when Tony called the police on late October 2019. Alex had alleged an assault by Penny. Evidence shows though that the police response was in line with policy and proportionate and that no one dealing with the incident (with the information

[33] ASC: Avon & Somerset Constabulary

the police held) could have or should have anticipated Penny taking her life so quickly afterwards.

14.1.8 Recommendations and implementation: None

14.2 Somerset Children Social Care IMR (CSC)

14.2.1 CSC had two contacts with Penny and her previous partner in 2009. The IMR author recorded that the first contact was relating to the break-up of their relationship and an argument over his property. It stated that now the parties had separated that there was no further chance of escalation and this was the first domestic incident with no physical violence.

14.2.2 The second incidence was about a male sending harassing text messages (presumed to be from her ex-partner) and a phone call to Penny with the message insinuating that he would burn the house down.

14.2.3 The later contacts related to Sam making allegations against Tony about being assaulted on more than one occasion. Although CSC identified that Sam had suffered emotional harm the matter was being investigated by the police and Sam was now living with his biological father. The police continued to investigate the domestic abuse between Penny and Tony, but it did not reach a referral for CSC.

14.2.4 The final contact with CSC was when Penny died. Sam was already with the biological father (Chris) and Alex was with Tony. Despite Tony being a previous perpetrator of domestic abuse with Penny, it was felt he could care for Alex.

14.2.5 Lesson Identified; *None.*

14.2.6 Actions to be Implemented*: None.*

14.3 HEALTH; Somerset Clinical Commissioning Group (CCG)

14.3.1 The Somerset CCG (the GP) had the following contacts with Penny; nine for depression, six for back pain and other minor conditions, 7 for obstetric and twelve for other issues for the period of the DHR review. Penny was given medication for her depression and information about self-referral to Talking Therapies. Penny did disclose to the GP that she had recently split from Tony but there was no evidence to suggest whether domestic abuse was explored. It is also not clear whether the GP had sight of the police DASH (March 2019) or whether the EMIS[34] system had alerts or a problem list to state that a DASH had been received.

14.3.2 LESSONS IDENTIFIED: The IMR author noted that police reports could have usefully triggered a routine enquiry about domestic abuse in consultation / discussion with a GP safeguarding lead and / or discussion in the practice safeguarding / complex case meetings. If appropriate, further enquiries and referrals could have been made e.g. to SIDAS.

14.3.3 Actions to be implemented:

[34] EMIS -a clinical IT system which supports healthcare teams across all settings. It allows health professionals to view a patient's full history in real time.

i. *Alerts in GP electronic patient record 'problem lists' to be placed on clinical systems after a DASH is received.*

14.4 Somerset NHS Foundation Trust (NHS Trust)

(*Information provided via a letter.)*

14.4.1 Within the time frame of the TOR of the DHR there was one contact with Penny via a request from a physiotherapist at the local hospital, to refer Penny to the Proactive Scheme for lifestyle support which was for physical exercise for chronic back pain.

14.4.2 Outside the scope of the review, the NHS Trust identified that Penny was referred to the Community Mental Health Service (CMHS) in 2005 and 2006 as she was experiencing periods of depression and anxiety associated with relationship difficulties and low self-esteem. The GP referral said Penny had received counselling and on two occasions had taken an overdose. The last assessment by CMHS in 2006 indicated that Penny was having recurring problems with overspending, debt, drugs and alcohol abuse resulting in guilt and low mood.

14.4.3 Lessons Identified: *None*

14.4.4 Actions to be implemented: *None.*

14.5 Somerset Integrated Domestic Abuse Service (SIDAS)

14.5.1 SIDAS was in contact with Penny from the end of March 2019 until her death in late October 2019. SIDAS had face to face contact with Penny on four occasions and this was supplemented with lots of telephone support.

14.5.2 The SIDAS case notes demonstrated that there was a good level of engagement from Penny. There was the odd occasion where there appeared to be some disengagement, but this appeared to be related to Penny's work commitments (The Independent Chair did try to gain information as to what Penny's employment was and cleaning was suggested but this could not be confirmed).

14.5.3 There were clear support needs identified, housing, legal issues concerning property ownership and child contact. The IMR author noted that all the issues were addressed appropriately by SIDAS and followed up according to procedures.

14.5.4 On reviewing the case files (with the benefit of hindsight) a good learning point would have been to check in on how a client is feeling and coping and to ensure this is recorded. Staff did check on how a client was feeling but recording was sporadic - there were no records of any deteriorating mental health issues relating to Penny.

14.5.5 The DHR Panel request that the provider of Domestic Abuse Services in Somerset ensure that professionals understand the link between mental health and domestic abuse and have a thorough understanding of suicide prevention. It recommends that professionals working in DA support services understand how to assess mental health needs. See Practice Briefing - Mental Health (Safelives)[35]*.*

[35] www.safelives.org.uk Practice briefing -mental health pdf.

14.5.6 Lessons Identified: *Increased check in with a client to see how they are.*

14.5.7 Actions to be implemented**:** *Case workers to check in more on client's feelings and mental wellbeing, ensuring that this is fully recorded. Signposted as required.*

14.6 South Somerset District Council (SSDC)

14.6.1 Penny was seen seven times between May and September 2019, by 6 different officers and two different teams. A named case officer had contact with Penny 11 times during the DHR review period, two of which related to DA. There was one previous contact in 2009 when Penny was experiencing DA in a previous relationship.

14.6.2 The contact, the housing decisions and interventions appeared to have been within SSDC housing policy.

14.6.3 The IMR author noted that when DA is disclosed, it is SSDC practice to carry out a DASH risk assessment and to forward this to SIDAS. Evidence suggested that there were opportunities to do this and to identify any risk of harm, other support needs and determine whether a referral was necessary**.**

14.6.4 Lessons Identified: *SSDC is a learning organisation and it would be beneficial to improve the understanding of domestic violence in all its forms and the importance of assessing the risk to the individual and dependents.*

14.6.5 ***Actions to be implemented.***

i. Mandatory DASH risk assessment training for all frontline staff to help identify and respond to disclosure of DA.
ii. Introduce a standard referral to a dedicated Case Officer if DA is disclosed.

14.6.6 The DHR Panel would recommend to SSDC that they participate in multi- agency DA training to respond to the Coordinated Community Response Model.[36]

14.6.7 The DHR Panel would recommend that SSDC increase their knowledge of pathways to get help, i.e. SIDAS/MARAC referral pathways.

14.6.8 The DHR Panel would recommend that SSDC implements its new housing strategy which should complement the Somerset Housing approach and reflect new legislation as identified in the Domestic Abuse Bill 2020.

14.7 Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company (BGSW CRC) Probation

14.7.1 Tony attended an induction workshop, four appointments with his Responsible Officer and eight unpaid work sessions.

14.7.2 Lessons identified**:**

[36] www.standingtogether.org.uk Coordinated Community Response

i. Although there was the required level of contact between Tony and the RO, there was little professional curiosity. A more investigative approach would have allowed additional information to be gathered to further assess and manage risk.
ii. It was noted that the Unpaid Work Requirements (UWR)[37] and the Rehabilitation Activity Requirement (RAR)[38] was not delivered. Tony did not carry out his UPW on five occasions. On commencement of the order a RO should have planned for the RAR through attendance of structured groups and referral made to the Intervention Team. Whilst waiting for the allocation to a group no structured interventions took place to identify risks.
iii. When a Service User is known to be a perpetrator of domestic abuse, in addition to an OASys[39] assessment, a Spousal Assault Risk Assessment (SARA) should also have been completed.
iv. Although there is nothing to indicate that Tony posed a direct risk to children, the domestic nature of his offending meant that any child present within the home would be at increased risk of witnessing domestic abuse. In addition, Tony directly abused Sam. There was no enquiry into Tony's new partner and whether she had children which was a significant omission as no safeguarding checks were taken for the new partner or if applicable her children.

14.7.3 Actions to be implemented:

i. Rational to be provided when assigning a BRAG status (now RAG+P).
ii. Correct layer OASys to be used when assessing Service Users.
iii. Standard of Risk Management Plans (RMPs) to be improved.
iv. Work to be undertaken around the inclusion of Service Users in the development of their Sentence Plan.
v. ROs to ensure structured interventions are delivered to Service Users to address the risk of re-offending and risk of harm posed.
vi. ROs to demonstrate effective management in domestic abuse and child safeguarding cases. To include assessment and planning; investigative approach; delivery of structured 1:1 intervention; case recording and effective interagency liaison with Police and CSC.

15. ANALYSIS

15.1 This analysis is based on information provided in the IMRs and responds to the key lines of enquiry as detailed in the TOR and issues that have arisen in consultation with professionals. Where relevant this includes an assessment of appropriateness of actions taken (or not) and offers recommendations to ensure lessons are learnt by relevant agencies. The Chair and the Panel are keen to emphasise that these comments and recommendations are made with the benefit of hindsight.

15.2 From information provided, Penny experienced domestic abuse in a previous relationship and for many years suffered from depression and anxiety with a feeling of worthlessness.

[37] Unpaid work requirements- part of Rehabilitation Activity Requirement
[38] RAR: Rehabilitation Activity Requirements
[39] OASys Service User Assessment System Probation Service

15.3 Penny and Tony were in a relationship for several years (approx. 10) and although there were a few contacts with the police, children services and health before the assault on Penny by Tony, the number of agencies involved with the family increased after the assault in March 2019.

15.4 The relationship between Tony and Penny appeared to end following the assault although information provided quotes “they still loved each other”

15.5 Following the separation, Penny’s mental health appeared to deteriorate, Tony was undermining Penny stating, “she was a bad mother” and using the custody of Alex to cause further mental anguish for Penny.

15.6 Penny allegedly assaulted Alex prior to taking her own life.

15.7 Key Themes were identified through the IMRs and discussion with professionals involved with the family:

- Domestic Abuse: physical and coercive and controlling behaviour.
- Mental Health Issues relating to Penny.
- Lack of professional curiosity around DA.
- Impact of Domestic Abuse on children including self-harm and grooming of children.
- Triaging of information between agencies.
- Substance abuse: Tony as the perpetrator of domestic abuse.
- The risk to a parent of loss of a child through custody.
- A victim being in repeated domestic abusive relationships.
- Economic Abuse.

15.2 Consider how (and awareness of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large - family, friends and statutory and voluntary organisations?

15.2.1 It is clear from the chronology that the police and SIDAS had a thorough understanding of domestic abuse in all its forms, including controlling coercive behaviour. What is not so clear is whether professionals including health professionals, schools and other agencies have a clear understanding of DA in all its forms.

15.2.2 Evidence shows that Tony was undermining Penny following the breakup of their relationship and his subsequent criminal conviction for assault on Penny. Penny informed SIDAS that Tony was threatening to take Alex. She was so concerned that she was fearful of letting Alex go to stay with Tony, thinking that Alex would not come back. Tony was also undermining Penny about the house that they had bought together which would appear to have increased Penny’s concerns further.

15.2.3 At one of Penny’s meeting with her SIDAS case worker she said, “things were better with Tony as he was not being physical”. Tony also said that Penny had no marks on her when he tried to strangle her.

15.2.4 The new Domestic Abuse Bill 2020 will include non-fatal strangulation a specific criminal offence in England and Wales. At present, the Police can only act under common assault and

as in many cases there is little sign of injury then non-fatal strangulation is overlooked. The non - fatal strangulation will require police and the criminal justice system to treat such cases with the gravity they deserve. Perpetrators could face up to seven years in jail[40].

15.2.5 Coercive control is not primarily a crime of violence but, as Evan Stark (2007)[41]describes, it is a 'liberty crime'. Stark provides a breakdown of coercive controls, e.g. degradation and shaming. Tony stated that Penny was a bad mother, his behaviour was intimidating and he threatened Penny that he wanted custody of Alex.

15.2.6 A comment was made by a professional that the issues between Penny and Tony were not DA related but appeared to be child contact issues. In the last few months of Penny's life, Tony exhibited controlling and coercive behaviour around child contact and finances to the house and Tony also degrade and shamed Penny by saying she was a "terrible mother".

15.2.7 Research by Women's Aid identifies that abuse does not stop when a relationship ends. Perpetrators use family proceedings and child contact arrangements to continue to control and abuse. It states that professionals involved in custody proceedings do not understand coercive controlling behaviour and can revert to victim blaming[42].

15.2.8 The Ministry of Justice, Assessing Risk of Harm to Children and Parents in Private Law Children's Cases Implementation plan June 2020[43], recognises the need to protect domestic abuse victims so they have the confidence to come forward and repost their experience, safe in the knowledge that the justice system and other agencies will do everything they can do to protect and support then and their children and pursue their abuser.

15.2.9 Some of the examples identified within the review would indicate that, despite controlling and coercive behaviour becoming a crime in The Serious Crime Act 2015 [44], some professionals and especially the wider community, do not understand DA in all its forms.

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

Following the DA incident in March 2019 there were several interventions which were used or could have been used to support Penny and the children.

Civil Interventions

a) Intervention of specialist domestic abuse services.

15.3.1 Following the domestic abuse incident on 24 March 2019, the police made a referral to LSU (Lighthouse Safeguarding Unit) who referred the case to SIDAS three days later. SIDAS supported Penny until her death.

[40] www.independent.co.uk 11 January 2021 non-fatal strangulation to become a criminal offence after calls from domestic abuse campaigners. Maya Oppenheim
[41] Stark. E Coercive control. The entrapment of women in personal life. 2007
[42]www.womensaid.org.uk "Abuse does not end when a relationship ends "Lucy Hadley 25 June 2020
[43] The Spotlight Review on domestic abuse – where does it fit in with other court reforms? | The Transparency Project Assessing Risk of Harm to Children in Private law Children Cases -Implementation Plan June 2020
[44] Serious Crime Act 2015: Measures introduced to enhance protection of vulnerable children and others including strengthening the law to tackle female genital mutilation and domestic abuse.

15.3.2 The communication and referral process between the police beat team, LSU and SIDAS worked well and speedily. The DA incident between Penny and Tony happened on 25 March 2019 and the referral was received by SIDAS, 27 March 2019, with the first contact being made with Penny on 2 April 2019.

15.3.3 SIDAS provided an IDVA who built a relationship with Penny and provided advice and support around housing, legal issues relating to her separation from Tony, custody issues and suggesting a restraining order against Tony to help create space for Penny to get her housing situation sorted and to help with her anxiety.

15.3.4 The IDVA supported the coordination of the Team around the Child (TAC) with Alex's school and there appears to have been good communication between the school and SIDAS. For several reasons, the TAC did not take place before Penny's death.

15.3.5 Timeliness of interventions by agencies is especially important when supporting victims of domestic abuse and their children. Penny was experiencing several traumas; mental health issues, trying to find somewhere to live, financial issues and custody issues. Alex was expressing confusion about the break - up of the relationship between Penny and Tony which was resulting in behaviour that added to Penny's trauma. A joint study "Jumping through the hoops" [45]quotes trauma as follows:

"When you are in a traumatic/abusive situation your body runs on adrenalin, but when you leave you become withdrawn, tired, lonely and you cannot cope. There is no safety net to catch you".

13.3.6 Professionals need to understand about the number of traumas, a victim of domestic abuse can be experiencing in order to provide support and interventions in a timely manner.

b) Interventions from Alex's School

15.3.7 Alex's school were notified through the Domestic Abuse Schools Protocol[46] (DASP) which advises schools of any incidents police are called to and a child is present. The first contact was about an incident between Penny and Tony on 8 March 2019. It is unclear is whether the second incident on 25 March 2019 was reported to the school via DASP. Penny herself informed the school about this incident.

15.3.8 The school was very supportive of Alex and of Penny following the assault by Tony in March 2019. Alex was offered the following services:

- Nurture check ins
- ELSA support
- Close monitoring in school
- 1 to 1 sessions
- Team around the Child (this was being arranged when Penny died.)

The school also gave advice to Penny about SIDAS, behaviour techniques to protect Alex e.g. Penny and Tony not to argue in front of Alex. There is no evidence to suggest that Tony was

[45] Jumping Through the hoops; How are coordinated responses to multiple disadvantages meeting the needs of women. August 2018 AVA, St Mungo's, Mind, MEAM
[46] Domestic Abuse Schools Protocol, Education Services.

spoken to despite him having contact with the school when he collected Alex. It is imperative that victims and perpetrators are given the same guidance, or it could appear that professionals are victim blaming.

15.3.9 Evidence from the school and relevant IMRs indicates that the school provided several positive interventions to support Alex especially and Penny. The school has several designated safeguarding leads and officers. There are protocols and procedures in place to support children and families living with domestic abuse and a regular programme of training for all staff around domestic abuse.

c) Interventions to support Penny's Mental Health

15.3.10 The facts in section thirteen of this report and notes written by Penny prior to her death highlight that she suffered from anxiety, depression and sometimes feelings of worthlessness and not being able to provide for the children.

15.3.11 In Penny's note written in July 2019 she said:

"Everyone keeps telling me to be strong but how can I when I'm breaking up inside. I have never felt pain like this, and I have felt plenty".

15.3.12 Penny had been treated for intermittent depression by her GP since 2005 with interventions such as medication (including fluoxetine and finally sertraline), support in 2006 by the Community Mental Health Team and access to Talking Therapies by self-referral.

15.3.13 Research suggests that women experiencing domestic abuse are more likely to experience mental health problems, whilst women with mental health problems are more likely to be domestically abused with 30-60% of women with mental health problems having experienced domestic violence[47].

15.3.14 There is no evidence to suggest that the GP explored domestic abuse with Penny, and it was not clear whether the GP practice had sight of the Police DASH following the domestic abuse incident in March 2019. GPs use the EMIS system for alerts or problems to state that a DASH has been received and nothing was recorded.
If the GP had received the DASH, then this could have usefully triggered routine enquiries about domestic abuse in the consultations that Penny had with her GP following the incident in March 2019. The inquiry would have also been discussed with the practice GP safeguarding leads which could have led to further enquiries and referral to other services.

15.3 15 GPs are now working together to share common systems including using the same flags/codes on their patient records including for domestic abuse. This development should enable GPs to make enquiries with a victim around domestic abuse and have a comprehensive overview as to what agencies may be involved with the victim and what additional health support may be needed. This should therefore provide a more coordinated support approach for the victim.

d) Interventions from Housing Support

[47] Mental health statistics; domestic violence www.mentalhealth.org.uk

15.3.16 With the breakdown of Penny and Tony's relationship, Penny was in desperate need of housing. Penny visited the SSDC housing department on eleven occasions (including two in relation to DA) from 2011 up to her death, to try to find accommodation for the family. The SSDC IMR identified that Penny saw several different case officers during her visits. She also had several forms to complete to apply for housing in the private sector, including an application for Homefinder Somerset and the property bond scheme. Penny was also told that she needed to get the Environmental Health Department to have a site visit to the house she and Tony owned, so there could be confirmation that the house was inhabitable.

15.3.17 There is evidence to show that Penny was struggling with her housing application in September 2019 as she asked her IDVA to attend meetings with her at the housing department and for help filling in the relevant forms.

15.3.18 The SSDC IMR states that there were several opportunities for the housing department to consider carrying out a DASH which could have identified the risks and support that Penny may need including her mental health needs.

15.3.19 Kelda Henderson (in research around the role of housing in a coordinated response to domestic abuse 2019) states that housing is often overlooked in favour of the criminal justice dominance within a community response to domestic abuse. This is changing with increasing attention on the role of housing. Her research also found that whilst housing providers have an established role in a coordinated community response to anti-social behaviour (ASB) this is not replicated in relation to domestic abuse[48].

15.3.20 Westminster Kensington and Chelsea have co located all their housing services together with direct services for victims where case management support can be offered to victims. Such a model would be difficult to replicate in a two-tier local authority model, to have a named housing officer for a victim of domestic abuse could enable the support needed to navigate the housing requirements. In the case of Penny, a named housing officer would have built a relationship with Penny and SIDAS and helped support contact with the environmental health department at a time when she was struggling to cope.

15.3.21 The Domestic Abuse Bill 2020[49] will provide that all eligible homeless victims of domestic abuse have "priority" needs for homelessness assistance. It will also ensure that where a local authority, for reasons connected to domestic abuse, grants a new secure tenancy to a social tenant who had or has a secure lifetime or assured tenancy this must be a secure lifetime tenancy.

15.3.22 When the Independent Chair met with members of the SSDC housing team the opportunities that the Domestic Abuse Bill 2020 will provide were explored. SSDC have developed a Housing Improvement Plan which includes having a named case officer for a victim of domestic abuse in need of housing support. This will ensure that the needs of the victim are managed appropriately but also a relationship can be developed between the case worker and victim. In Penny's case, she needed support filling in forms and specialist information from

[48] Henderson. Kelda the role of housing in a coordinated community response to domestic abuse 2019 Kelda_Henderson_Thesis_2018_December_Formatted_2019.pdf (dur.ac.uk)
[49] www.gov.uk/government/publications/domestic-abuse-bill-2020wi

Environmental Health. A dedicated case worker would have supported Penny in navigating what she needed to do.

15.3.23 SSDC have stated that they will be investing in the development of a local peer support group for victims of domestic abuse which is expected to provide opportunities for agencies to identify what support is needed for victims of domestic abuse but also enabling victims to support each other.

15.3.24 Homefinder Somerset is a county wide choice based letting scheme where an applicant can bid for a social housing property anywhere in Somerset and therefore may move from the host local authority. The expectation is that the Domestic Abuse Bill 2020 will provide the opportunity for a common protocol across Somerset relating to supporting the needs of victims of domestic abuse.

e) Interventions - Substance Misuse

15.3.25 Information within the IMRs and confirmed by Tony himself, states that he was an alcoholic. At the first domestic incident on 3 March 2019, Penny disclosed that Tony was struggling with alcohol, which was putting pressure on the family. It is unclear whether this was considered a safeguarding issue by the police.

15.3.26 International evidence reveals that men (but not women) tend to perpetrate more severe assaults when they have been drinking[50]. Since 2011, substance use has been detected among domestic homicide perpetrators more than four times as often as it has among those killed by them.

15.3.27 The 2019 Domestic Abuse Bill proposes to widen the scope of Domestic Abuse Protection Orders so that perpetrators of domestic abuse can be compelled to attend drug or alcohol treatment.[51]

15.3.28 When Tony was convicted in April 2019 this intervention was not available but whether his substance abuse was considered an issue is unclear and research shows it should be considered in risk management for the victim. A drug and alcohol support worker could have spoken with Tony whilst in custody or whilst he was carrying out his RO work about his use of alcohol and this was a missed opportunity to offer support.

15.3.29 Although there is no evidence provided by agencies that Penny had any issues with alcohol misuse, there were several examples of her being intoxicated through alcohol. Penny was seen in her local town quite intoxicated, Tony stated that Penny was very intoxicated the night she allegedly assaulted Alex. Alex's school challenged Penny about her alcohol consumption and offered information about alcohol support organisations. Penny denied she had a "drink problem" and that she had only had a "couple of glasses a night". There is some evidence to indicate that Penny did have a recurring issue with alcohol and it was never

[50] Graham, Bernards, Wilsnack, S and Gmel, G 2011) Alcohol may not cause partner violence, but it seems to make it worst, Journal of Interpersonal Violence
[51] HM Government 2019 Domestic Abuse Bill

considered an option by agencies to refer Penny to Somerset Drug and Alcohol Service which may have provided extra support for Penny.

15.3.30 It is well documented that many victims of domestic abuse suffer mental health issues and substance abuse. Victims often state that they drink alcohol to numb the physical and emotional pain. Also, difficulties with alcohol and the existence of depression were likely to increase a victim's suicidal tendencies[52].

15.3.31 Somerset Drug and Alcohol Service provides a range of support for alcohol issues not just addiction. They provide support for those who binge drink or want to reduce their alcohol intake. Such a service could have provided some support to Penny which may have helped. "The comment was made that Penny would have been devastated to think she had assaulted Alex".

Legal Interventions

a) Restraining Order.

15.3.32 A restraining order or protective order can be issued by a judge at the end of criminal proceedings to prevent someone from causing harm to someone else, in situations involving domestic violence, harassment, stalking or sexual assault. The restraining order puts restrictions on the offender for the purpose of stopping them causing further harm (physical/emotional) to a victim. A restraining order is preventative, not punitive. Restraining orders are most appropriate where a perpetrator of DA and the victim are known to each other and where there is a continuing risk to the victim of harassment or violence after the date of conviction[53].

15.3.33 Following Tony's conviction in April 2019, a restraining order was not put in place by court. Although Penny provided a statement to the police, she refused to attend the court but did not want to decline the allegation. Penny declined any RO and supported this by saying that neither Tony nor his family had made any attempt to contact her. This would appear to contradict what Penny told a teacher at Alex's school. Penny confided that Tony's family wanted her to drop the charges against him and that she felt under pressure.

15.3.34 In June 2019, Penny advised her IDVA that Tony was continuing to harass and intimidate her, especially around child contact. The IDVA advised Penny to consider a non-molestation order, but Penny did not pursue this option. It is unclear why Penny did not pursue a RO or an NMO. Information indicates that Penny may have felt under pressure from Tony's family or that she had enough issues to try and cope with such as

- Finding a home
- Starting a new job
- Financial pressure
- Custody Issues
- Ongoing harassment from Tony

[52] Domestic Abuse and Suicide Ruth Aitken and Vanessa E. Munro 2018
[53] CPS.gov.uk

15.3.35 The DHR Panel did consider whether the Court, at Tony's trial in April 2019, could have made an application for a RO. Following discussions between the Independent Chair and Crown Prosecution Service (CPS) it may have been difficult to provide sufficient evidence in the case of Penny.

15.3.36 Whilst restraining orders are civil behaviour orders, the CPS Prosecutors can make an application to the court on either conviction or acquittal of a defendant but where possible the victims needs and wishes should be considered. Prosecutors are advised whether an application would be suitable on a case-by-case basis and to whether it will keep a victim safe. This is important where a victim and perpetrator are still in a relationship, whether they attend the same workplace/university etc and where child contact arrangements need to be considered. The Prosecutors would also seek the views of any support services assisting the victim to assess risk e.g. the police and specialist domestic abuse services.

15.3.37 The Police did not make a representation to the CPS because Penny only provided a statement for Tony's criminal case as she did not want to be a witness at the trial and therefore a RO was not pursed by the police. A potential reason that Penny was not a witness could have been associated with pressures from Tony and his family to drop the charges as she disclosed to the school but not to the police. Penny only became involved with an IDVA (SIDAS) following Tony's conviction and therefore the IDVA was not able to make representation to the CPS before Tony's trial.

15.3.38 Professionals need to understand that a RO is an intervention that can be used to protect a victim of domestic abuse but that the wishes of the victim needs must be considered and there must be sufficient evidence for the CPS to view that an order is necessary. The CPS guidance also states that in some cases a victim may not want a restraining order to be imposed, as the victim may want to continue a relationship with the defendant, for example (RvBrown (2012) EWCA Crim 1152 and RvPicken (2006) EWCA Crim 2194). In such instances the Prosecutors should not object to the victims wishes but inform the court as it is ultimately a matter for the court"[54].

b) Domestic Violence Protection Notice (DVPN)

15.3.39 A DVPN is an emergency non-molestation and eviction notice which can be issued by the police, in the aftermath of domestic violence. It enables the police and the magistrates court to put in protective measures in the immediate aftermath of domestic violence where there is insufficient evidence to charge perpetrators and to provide protection to a victim via bail conditions.

15.3.40 Tony was arrested, charged and convicted of a domestic abuse offence and he went to live with his mother following the incident in March 2019. The DVPN therefore was not necessary for Penny.

[54] www.cps.gov.uk restraining orders section 5 Protection from harassment Act 1997 Views of Victims

15.3.41 A DVPN can be a useful tool to support victims, but the Centre for Women's Justice (CWJ) argues that Domestic Violence Protection Notices (DVPNs) and Orders introduced (2014) as an additional protection for women were "rarely used"[55].

15.3.42 The Domestic Abuse Bill 2020 will deliver a Domestic Abuse Protection Order that will:

- Prioritise the safety of survivors,
- Result in a criminal sanction if breached by the perpetrator,
- Places responsibility on the perpetrator to stop abuse,
- Is supported by training and guidance for professionals including, but not limited to, police, courts, social care, health care professionals and local authority housing teams.

15.3.43 In future, a victim of DA, in a similar situation to Penny could have protection from a DVPN, for example to stop a perpetrator continuing to coerce, control and harass a victim.

c) Domestic Abuse Triage (DAT)

15.3.44 The DAT pilot was set up in September 2019 prior to Penny's death and the alleged incident of Penny assaulting Alex was referred to a DAT, but Penny died before this took place. The DAT was set up as a means of triaging police referrals due to the high number that were being sent to CSC that did not meet thresholds. The minutes of the meetings were held on individual police records, but CSC withdrew from the process since there was no documented account of what was being discussed at the DAT, the rational as to why an agency was not accepting a referral and cases were presented on an isolated basis and did not provide a history/background of the victim.

15.3.45 The pilot DAT project is no longer in operation. Somerset Safeguarding Children Partnership have been carrying out a Child Safeguarding Practice Review "Charlie" (CSPR) which has also identified that the DAT has been difficult to implement. This DHR and the CSPR highlights the different perspective that the police and CSC held about why the DAT was established, different views about the scope of the DAT, was it high risk DA cases or all DA cases etc. It would also appear that the focus was about managing demand as opposed to optimising the contribution of partner agencies in triaging domestic abuse incidents. The initial DAT project was not linked to any formal governance and therefore the responsibilities of agencies was not monitored.

15.3.46 Somerset Foundation Trust were the only health provider at the beginning of the DAT process but withdrew due to capacity issues and concerns about the governance of the process. Somerset CCG were not involved and GPs may have been able to provide information and support for a victim of DA.

15.3.47 Agencies and practitioners value a multi- agency model to support victims of domestic abuse which complements existing safeguarding support, MARAC and the MASH but there needs to be challenging conversations with agencies to develop a model that works to support victims of DA. The model should include;

[55] New bail reforms were failing the victims of domestic abuse and harassment Jon Robins 2019. www.thejusticegap.com

- Formal Governance
- Clear Aims and Objectives which complement the MARAC and the MASH.
- Common Purpose
- Common procedures
- Understanding of agency thresholds
- “Buy in” from all relevant agencies with commitment and resources.

15.4 Multi Agency Risk Assessment Conference (MARAC)

Following the incident in April 2019 when Tony assaulted Penny and was later convicted a referral was made by SIDAS to a MARAC. SIDAS noted on 25 April 2019 that the referral had been removed from the MARAC listing due to the outcome of Tony’s trial, the conviction for Tony assaulting Penny.

There appears to have been no consideration by professionals using their professional judgement, that a MARAC would have been a beneficial intervention for Penny and her family. Although the domestic abuse incident was one reported incident there were many known risk factors , alcohol, mental health, debt and child custody. A MARAC would have allowed professionals to identify all the risks for Penny and the family and therefore a more coordinated approach to the safety planning for Penny and her family.

15.5 To consider the risk and impact on the separation of children and victim.

15.5.1 Evidence from Penny’s family was that Penny loved her children and tried to be the best mother she could, helping at Alex’s school with swimming and keeping in regular contact. Penny also engaged with agencies following the assault on her to try to set up the best possible family life she could for Alex. There is evidence to suggest that Penny was drinking a lot following the break- up of the relationship with Tony. Parents at Alex’s school said they had seen Penny ‘out on the town’ and she was very intoxicated. Tony said the night Penny allegedly assaulted Alex at her home, she was so drunk she did not know what she was doing. Tony said that if Penny had been sober, she would have been horrified about her actions. Tony said Penny loved Alex.

15.5.2 Research identifies that there are several protective factors that can prevent a woman taking her own life which includes motherhood and the strong maternal bond[56]. Penny regularly spoke to professionals about the concerns she had around custody of Alex. Following the incident on **24 October 2019** Penny may have been very vulnerable following the incident and concerned about whether her behaviour would impact on her having custody of Alex.

15.6 To determine if there were any barriers Penny or her family / friends faced in both reporting domestic abuse accessing services. (This to be explored against the Equality Act 2010’s protected characteristics.

15.6.1 Penny was more likely to have suffered domestic abuse because she was a female. Research show that females are more likely to be repeat and chronic victims of domestic abuse. There is some evidence to suggest that Penny experienced domestic abuse in several relationships. There were previous incidents between Penny and Tony prior to his assault on

[56] Women and Suicide Centre for suicide prevention www.suicideinfo.ca

her in March 2019. Penny spoke with the school saying that his family wanted her to drop the charges against him for the assault, but she was fearful that he would continue with such behaviour. There is no evidence to suggest that Penny tried to access domestic abuse services prior to March 2019.

15.6.2 Tony was arrested in late March 2019 following the common assault and battery incident when he put his hand around Penny's throat. Tony was charged and later released on bail. A DASH was completed and was rated as Medium. A BRAG was completed and rated as green noting that this was the second incident in 22 days and that Tony had been drunk on both occasions. The police made a referral to the LSU and referrals were made to education and health for the children and SIDAS.

15.6.3 Following the referral to SIDAS, Penny was allocated a case worker who worked with Penny to provide advice about housing, legal issues concerning the property ownership and child contact. Financial abuse is a form of coercive control. Tony was using the home ownership/selling the property to undermine Penny and control the situation about when she would receive her part of the proceeds allowing Penny to find a new home. This added to the considerable trauma and stress that Penny was experiencing.

15.6.4 Penny appeared to liaise with SIDAS regularly although sometimes Penny could not be contacted. She had started a new job and was under a certain amount of pressure relating to financial concerns and the need to find a new home for her and Alex.

15.6.5 Professionals sometimes state 'the client did not engage' instead of exploring the reasons for this. The SIDAS case worker did appear to fully understand the many pressures that Penny was experiencing.

15.6.6 Although the Somerset DA Support Referral Protocol appears to have been implemented correctly following the incident of Tony's assault on Penny, it would appear there is no evidence that the GP had sight of the Police MASH referral. The CCG IMR highlights that it was not clear whether the EMIS systems had an alert to say a DASH had been received.
If the GP had received the DASH information this would have given the opportunity to discuss domestic abuse and Penny's symptoms of depression when she visited the practice in September 2019.

15.6.7 SIDAS have also identified the need to check in with a client to assess their wellbeing and that this should be recorded and action taken to help if required, including referral or help to access other services. Research highlights those women experiencing domestic abuse are more likely to experience mental health problems whilst women with mental health problems are more likely to be domestically abused, with 30-60% of women with a mental health problem having experienced domestic abuse.[57]

15.6.8 Although the GP was aware of Penny's anxiety and depression, other agencies supporting Penny were not fully aware of her long history of mental health issues. If the GP had

[57] Mental health statistics; domestic violence. Mental health foundation. www.mentalhealth.org.uk

known of the domestic abuse incident in March 2019, further support may have been available to Penny.

15.6.9 When professionals are dealing with victims of domestic abuse, it is important that they build up the "complete picture" of a victim using professional curiosity. This can ensure that a victim gets all the support they need and that there are no barriers to interventions.

15.6.10 The review timeline did consider the period from when Penny was pregnant with Alex. What is not known from the information provided is whether Penny suffered any domestic abuse by Tony during her pregnancy. Professionals do need to be aware that pregnancy is a high-risk indicator of potential domestic abuse and as such, routine enquiry about domestic abuse with pregnant women by midwives, GP's and health visitors, is very important

16.0 LESSONS LEARNT

16.1 Information Sharing

Following on from the two domestic abuse incidents in March 2019, Penny and Tony were involved with several agencies:

- The police
- SIDAS
- GPs
- Alex's school.
- South Somerset District Council (Housing)

16.1.1 Although SIDAS was communicating with the school and SSDC, Penny's GP was not aware of the DASH in March 2019. This meant that not all Penny's support needs were considered. The DAT would appear to provide a useful information sharing and discussion forum but for some reason the incident on 25 October 2019 when Penny allegedly assaulted Alex was not discussed. Whether timely interventions and information about Penny's mental health could have been shared, enabling interventions to be implemented, is unknown.

16.1.2 GPs are often critical in ensuring that victims of domestic abuse receive support for all their needs. As already highlighted in the report, victims of domestic abuse are more likely to suffer mental health issues and substance abuse.

16.1.3 In July 2020, SCCG carried out a project around sharing information between police and primary care (GP's) during the COVID pandemic. The police send all domestic abuse reports to the DAT, which is triaged either to a MARAC (high risk) or to the MASH (where children are involved) and information is relayed in both models to the GP. For all the remaining cases there is no formal system to notify a GP and they are unaware of the abuse for such individuals. This identifies a gap in information sharing between the police and GPs.

16.1.4 The pilot project involved the LSU and the safeguarding team at the CCG. A secure email was set up and officers from the LSU were instructed to send all high-risk domestic abuse and medium risk referrals (subject to the victim agreeing the sharing of information) to the secure email. This email was monitored twice a week by a dedicated GP who identified the correct GP for the victim /perpetrator. The information was then sent to the relevant GP along with a link to

safeguarding resources within the CCG Safeguarding Team. Over a four-week period 126 reports were sent to 44 GP practices in Somerset and 7 reports to out of area practices.
The project found that having a single point of contact reduced the administrative burden on the police. Evidence also showed an increase in safeguarding referrals. A GP Safeguarding lead stated it was beneficial in getting a fuller picture of a victim's homelife and could only help in providing better care.

16.1.5 Whether such a model could have helped Penny access further support will never be known but for victims in the future such a model, if fully implemented, could ensure that all their needs are considered and supported.

16.1.6 Alex's school provided exemplary case notes for this DHR. The case notes gave the most detailed information and the best overview of what was happening in Penny and her family's life. Although the focus was around support for Alex, it also included the issues and contacts with Penny, Tony and Mary. Evidence shows that the school were in liaison with SIDAS but the information they gathered appears not to have filtered through to other agencies and this needs to be considered in any future multi- agency models for supporting families experiencing domestic abuse.

16.1.7 Alex's school have shown good practice around supporting a victim of DA and their family and the learning from this DHR should be disseminated to all schools in the locality through DA and safeguarding training.

16.2 Lack of understanding by professionals and the wider community of coercive controlling behaviour.

16.2.1 Despite controlling and coercive behaviour being embedded in domestic abuse legislation, it is the least understood aspect of overall domestic abuse and safeguarding law. All professionals need to think wider and seek to explore individuals with greater professional curiosity. Within several agencies IMRs there was the comment that "there was no physical abuse". The comment was made that issues seem to be about child contact and not DA, but Tony was saying to Penny "you are a terrible mother" and as Penny said, "doing her head in and "filling Alex's head with all sorts of things". These actions undermined and manipulated Penny and Alex.

16.2.2 Penny was also experiencing financial and economic abuse. Women's Aid define financial abuse as a pattern of controlling coercive behaviour which controls, threatens, and degrades and restricts a victim's freedom[58]. Economic abuse is defined by creating economic instability which limits women's choices[59]. Not all professionals or the community understand this form of abuse. Economic abuse can undermine the ability of a victim to leave an unsafe situation and although Penny had left the family home, she was the one who was homeless which added to the trauma and pressures she was experiencing.

16.2.3 The wider community needs a better understanding of coercive, controlling behaviour through national campaigns and information provided by Community Safety Partnerships.

[58] Women's aid. www.womensaid.org.uk
[59] Surviving Economic Abuse www.survivingeconomicabuse.org

16.3 Trauma Informed approach to Domestic Abuse

16.3.1 A accepted definition of trauma is an event, series of events or set of circumstances experienced by an individual as physically or emotionally harmful or life threatening and can have lasting adverse effects on an individual's functioning, (mental health, physical, social and emotional)[60]. Domestic Abuse is a form of trauma and often overlaps with mental health issues, as in the case of Penny and with substance abuse.

16.3.2 Research by Safe Lives identifies that when practitioners approach shifts from "what's wrong with this person (victim)" to "what had happened to this person" helps to understand the behaviour, needs and what support a victim may need[61].

16.3.3 Although there were many agencies involved with Penny and her family, there does not appear to have been a complete overview of the issues and traumas Penny was facing e.g. not all agencies were aware of mental health issues (police, SIDAS) and not all agencies were aware of Penny experiencing domestic abuse (GPs). It is important that if victims are to receive a coordinated response to their needs, agencies and practitioners need processes and training to understand and implement a trauma-based approach to supporting victims of domestic abuse.

16.4 Professional Curiosity and understanding the need to know the victim and better.

16.4.1 The review identifies that Penny experienced depression and anxiety over many years; she had once before tried to commit suicide, she had suffered domestic abuse in a previous relationship and in the last six months of her life she was trying to find a home, was worried about her financial situation and above all was concerned about the custody of Alex.

16.4.2 No single agency had a complete picture of Penny and her needs. The police responded to the incidents (as detailed in the facts) in a professional manner following policy, procedures and good practice, which did result in the conviction of Tony for assault and battery. There is no evidence to indicate whether there were any enquiries by the police about Penny's mental health. The GP IMR states that they did not see the DASH relating to the incident of DA in March 2019. If the DASH had been shared with health and especially the GP this could have built a more complex picture of Penny's needs and an enquiry could have been made with Penny when she visited the GP practice in September 2019.

16.4.3 The BGSW CRC highlights that that there was very little evidence of professional curiosity around the perpetrator of DA, Tony. It states that a more investigative approach would have gathered additional information to assess and manage any risks posed by Tony. It also states that Tony's threats towards Sam were either ignored or not known and it was assumed he posed no risk to children. The nature of his offending meant that any child present within the home would have increased risk of witnessing a domestic incident. It is documented in other agency IMRs that Alex was a witness to the domestic abuse and evidenced that Tony was influencing her following the break-up of the relationship. If professionals had been more curious, they may have been able to review the risks for Penny and Alex.

[60] www.samhsa.gov/tauma-violence
[61] www.safelives.org.uk

16.4.4 Somerset Safeguarding Adult Board has produced a guidance document about professional curiosity, what it is, the barriers and how professionals can be professionally curious[62]. This guidance could be helpful to agencies including organisations, schools, GPs local authority housing departments and it is important that professionals are made aware of its availability.

16.5 Risk and Impact of Separation of Children and the Victim

16.5.1 Evidence shows that Penny loved Sam and Alex and that the tensions between Sam and Tony resulted in Sam moving to live with the Chris (the father). This would have impacted on Penny and Alex. It has already been documented within the report that the visiting and custody rights for Alex was an issue between Penny and Tony. There were several disagreements between Penny and Tony about access and custody.

16.5.2 Following the incident in **late October 2019**, when Penny allegedly assaulted Alex, would have been devasting for Alex and Penny. Penny may have been concerned whether this incident would affect her getting custody of Alex. The Police call handler recorded a comment from Tony that the alleged assault would provide useful evidence for a solicitor in his attempt to get full custody of Alex. For whatever reason, this incident was not discussed at the DAT the following day in October 2019 and whether interventions could have been implemented to support Penny is not known as Penny took her own life three days later following the incident.

16.5.3 Parents can have a perceived fear of CSC through the media. Penny may have been fearful of what action CSC may have taken following the incident 24 October 2019. Previously, the CSC primary purpose was to protect and support a child with child protection systems being very adversarial and risk focused. Research tells us that parents often find it hard to seek support and have open and honest conversations with professionals and CSC through fear of being stigmatised[63].

16.5.4 Several local authorities are now practicing a Family Safeguarding Model which was first implemented in Hertfordshire County Council[64]. The focus of the model includes:

- Working in partnership with families instead of “doing to” families
- Enabling children to stay with their parents and/or wider extended family.
- Enabling families to develop their own care plan to address their child’s needs.

16.5.5 Family Support Teams include social workers along with domestic abuse practitioners, mental health and substance misuse specialists. Research identifies that the main risks for children are domestic abuse, substance misuse and mental health issues[65], of which, domestic abuse and mental health would have been relevant to Penny.

16.5.6 Somerset CSC implemented a Family Safeguarding Model in December 2020 which sees professionals working collaboratively with the family to support the needs to improve outcomes.

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[62] www.ssab.safeguardingsomerset.org.uk
[63] *https://www.socialworkengland.org.uk/media/3324/crd-public-percep…*
[64] Northamptonshire County Council Family Safeguarding. www.northamptonshire.gov.uk
[65] Children and family Court Advisory Service and Support Service (CafCass)

16.5.7 Agencies working with CSC have had workshops available to them to inform their understanding of the Family Safeguarding Model. The new model of working, which is based on trust and partnership between practitioners and families, may help dispel fear and distrust of CSC.

16.6 Impact on Children living with Domestic Abuse.

16.6.1 Although the TOR did not identify the children as a key line of enquiry, this review has given a detailed insight into the life of a child living with domestic abuse, which may help professionals when dealing with families with issues and needs in the future. Although Alex was not interviewed, the information provided by the school did give an insight into the impact DA had on Alex e.g.:

- “Dad tried to kill Mum by strangling her”.
- Alex started “playing up”.
- Alex started to self- harm by biting her arm.

Research shows that domestic violence has a devastating impact on children and young people which can last into adulthood. Symptoms can include.

- Becoming anxious or depressed.
- Alex self -harming and asking for a 'feeling fan' which demonstrated the impact on of witnessing DA.
- Having nightmares / flashbacks.
- Having physical symptoms e.g. wetting the bed, tummy ache
- Possibly becoming aggressive[66].
- Having nightmares / flashbacks

16.6.2 It is important that professionals working with families understand the impact on children of living with domestic abuse and have the tools to identify behaviours, listen and interpret the voice of the child to enable the whole family's needs to be better supported.

16.6.3 It is also important that children who have lived with domestic abuse understand what a healthy relationship looks like. The Department for Education identifies in the requirement of the Personal, Social, Health and Economic Education curriculum that relationships and sex education (RSE) are included[67]. Healthy and non - healthy relationships are considered which may help children who have been living with domestic abuse to understand what a healthy relationship is and what is not and therefore "break the cycle" of acceptance of domestic abuse, generation to generation. Alex's school provides an RSE programme base on the school's strategic vision and philosophy "Roots to Grow and Wings to Fly" (a vision developed by the school.) which includes learning about good and bad relationships and all schools should provide such learning.

16.6.4 Professionals should also consider what support services there are available in the area to support children and young people which may be of help to them. In Somerset, Somerset Drugs and Alcohol Services offer a programme called Hidden Harm[68] which is around supporting children around the potential impact of their parent's substance misuse, domestic abuse and mental health is having on them.

The Head Teacher at Rose's school spoke bringing the Young Victims programme provided by SIDAS[69] into the school to speak with and support children living with Domestic Abuse.

16.6 Post Review Learning

16.6.1 The updated DHR Statutory Guidance December 2016 advises that a DHR should be undertaken where it would appear someone has died unexpectedly in circumstances where there are concerns about domestic abuse, including controlling coercive behaviour. The process is about learning and not blame. However, some families struggle to understand why a DHR is required as there was no homicide[70]. The family felt the terminology was unhelpful. In the only

[66] Women's aid -The impact of domestic abuse on children and young people: https://www.womensaid.org.uk/the-survivors-handbook/children-and-domestic-abuse/
[67] www.gov.uk/government/publications/personel-social-health-ecocomice-education
[68] www.turning-point.co.uk
[69] www.theyoutrust.org.uk
[70] Homicide the killing of one person by another -Oxford Dictionary of English

telephone conversation with Penny's father, he was quite angry that such a review was taking place as the family had just started to move on and come to terms with Penny's death. The process brought it all back.

16.6.2 Penny died in **late October 2019**, the family were not aware of the review until April 2020 when the Independent Chair contacted them to introduce herself and give information around the DHR process.

The Home Office Guidance is that a family should be contacted in the first instance by the Community Safety Partnership once it has agreed that a homicide/unexpected death meets the criteria for a DHR.

It was noted by the Panel that the Safer Somerset Partnership should review its family notification process and contact a family as soon as it is agreed to carry out a DHR.

16.6.3 Following the death of Penny, Alex's school offered a comprehensive support programme not just for Alex but also Tony, including bereavement counselling for Alex and Tony. Monthly support meetings have continued between the school, Alex and Tony for the past year which has helped, especially for Alex, to navigate grief, memories of Penny and life events such as birthdays and the anniversary of Penny's death. It would be of benefit for the school to share the experience of supporting a child and the family following the death of a parent with other schools, via safeguarding training and the Safer Somerset partnership.

16.6.4 This was the first DHR that the school had been involved with. The Independent Chair did discuss the DHR process with the Head Teacher, but it would be of benefit for the Safer Somerset Partnership to make available to all school, information about what is a DHR based on Home Office Domestic Homicide Review Guidance 2016. The Head Teacher also stated that it was traumatic for the Designated Safeguarding Leads (DSL) to be involved in reviews, such as DHR's, Child Safeguarding Practice Reviews and relive tragic events. It would appear that schools are responsible for providing their own reflective supervision support and this may sometimes be limited due to budget constraints. Consideration may need to be given as to what support a local education authority can provide in supporting reflective supervision can to DSL's.

17.0 CONCLUSIONS

17.1 Penny's death was unexpected. Although Penny had attempted to take her own life many years earlier, she never spoke to professionals about her feelings, anxiety and depression in the last six months of her life. Penny was trying to arrange custody of Alex, finding a home for them both and trying to resolve financial issues. Penny engaged with professionals and was trying to carry out all she needed to do to get additional support and guidance.

*17.2 O*ne of Penny notes written in late July 2019 highlights the anxiety and despair that Penny appears to have been experiencing.

"*I am still in love with him, but the worst thing is our child would rather be with him and his new girlfriend playing happy families, this really hurts, and I feel as though I have lost Sam as well and now for what. I hate my life at this moment".*

17.3 There is no doubt that Penny would have been devastated about the allegation of her assaulting Alex on **24 October 2019** and evidence stating she had been drinking. Following the incident, Penny may have considered what the impact of the this would have on her having custody of Alex? Penny took her own life three days later having written notes for her children and parents.

17.4 The review has identified the tragic cost of domestic abuse including coercive control and mental health issues. The agencies involved with Penny did not appear to consider Penny's mental health (the bigger picture). If Penny's GP had been aware of the domestic abuse incidents in March 2019 there may have been some further interventions which could have supported Penny.

17.5 Penny's notes detailed how fragile she was, but she was also trying to resolve many issues, finding a home for her and Alex, seeking financial support, getting a new job, trying to resolve custody around Alex whilst experiencing Tony's undermining, harassment and verbal abuse.

17.6 When abusive relationships are breaking down or when partners separate there can be an increased risk of serious harm. Many professionals are aware of the risks, but this review also highlights the potential increased risk of losing a child through custody and professionals need to consider this risk and in future provide appropriate support.

17.7 Penny did receive support from specialist domestic abuse services, Alex's school, housing, her GP and the police but not all agencies fully understood what had happened in Penny's life, what was happening and therefore there was not a fully coordinated approach to the support that Penny received. The police, SIDAS and Alex's school were not aware of Penny's long history of mental health issues and the GP was not aware of the domestic abuse that Penny had suffered and was still experiencing including coercive controlling behaviour, being told she was a bad mother, using custody and finances to control and undermine Penny.

17.8 It is imperative that agencies work together to ensure that they fully understand the issues the person is experiencing and to understand what has happened in the past. This will enable professionals to "know the victim" better and enable the essential support they may need.

18.RECOMMENDATIONS

The following recommendations have been arrived at using a range of information sources: IMR recommendations / learning from the Review / the Review Panel's discussion and deliberations.

The recommendations are regularly monitored by the Somerset Domestic Abuse Board (a sub-group of the Safer Somerset Partnership).

1. Training Local

Recommendation One

The Safer Somerset Partnership will provide a minimum curriculum and training for all staff working with vulnerable adults, children and families. This will include an in depth understanding of DA, including controlling, coercive behaviour, a trauma-based approach of supporting victims

suffering DA, an understanding of the links between mental health issues, substance abuse and domestic abuse, professional curiosity, timeliness of interventions and the impact of the Domestic Abuse Bill 2020.

Ownership: Safer Somerset Partnership.

Recommendation Two

The Safer Somerset Partnership to seek assurance from public health (local) that all schools (state and private) are promoting Personal Social Health and Economic (PSHE) policies which support children living with DA and for all to understand healthy relationships.

Ownership: Safer Somerset Partnership

Recommendation Three

The Safer Somerset Partnership to request that Somerset District Councils include mandatory Induction Safeguarding training (including domestic abuse) for all front-line staff.

Ownership; Safer Somerset Partnership and Somerset District Councils Human Resources Dept.

2.Information Sharing/Referral Process

Recommendation Four

Safer Somerset Partnership and Somerset Safeguarding Children Partnership should consider whether a regional approach to domestic abuse notifications should be developed in collaboration with Avon and Somerset Strategic Safeguarding Partnership.

Implement a partnership approach to share information and analyse the needs of children living with domestic abuse.

Ownership: Chair of Partnership Business Group, Somerset Safeguarding Children Partnership / Safer Somerset Partnership.

Recommendation Five

To review the Somerset CCG Domestic Abuse Information Sharing project between Police and Primary Care (GPs) during COVID-19 Pandemic 2020. Investigate its wider implementation.

Ownership: Avon and Somerset Police and Somerset CCG

3. Housing

Recommendation Six

The Safer Somerset Partnership to promote a Whole Housing Approach to housing providers to enable the housing sector to improve housing options and outcomes for people experiencing

domestic abuse, so they can achieve stable housing, live safely and overcome the abuse and its harmful impact.

Ownership: Safer Somerset Partnership - Somerset Strategic Housing Officers

4. Other Local

Recommendation Seven

Agencies to implement the recommendations identified within their IMRs and provide an update report to the Safer Somerset Partnership on a quarterly basis.

Ownership: The Safer Somerset Partnership and all agencies included in this report.

Recommendation Eight

Safer Somerset Partnership to review how it informs families of the deceased that a Domestic Homicide Review will take place. This will include protocols for homicides and unexpected deaths.

Ownership: Safer Somerset partnership

5. National

Recommendation Nine

Safer Somerset Partnership to request the Home Office consider updating the Multi-Agency Statutory Guidance for a Conduct of a Domestic Homicide Review 2016 to include specific guidance where a person may have taken their own life. This review to include recommended terminology to replace the DHR use of homicide/victim/perpetrator to make it more transparent to a family why a review is required.

Ownership; Safer Somerset Partnership

APPENDIX ONE

TERMS OF REFERENCE FOR REVIEW PANEL

1. Introduction

1.1 The chair of the Safer Somerset Partnership has commissioned this DHR in response to the death of Penny which is believed to be suicide. This is within the statutory parameters for a DHR because the deceased was understood to be up until her death in a domestically abusive relationship with her estranged partner.

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

2. Aims of The Domestic Homicide Review Process

2.1 Establish the facts that led to the death in late October 2019 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.

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

2.3 To produce a report which:

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

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

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

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

3. Scope of the review

The review will:

- Consider the period from 01.06.2011 to late October.10.2019 (this is intended to cover the period from when Penny was pregnant with her youngest child) subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events that are relevant.
- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Domestic Violence Crime and Victims Act (2004) and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events. Taking account of the coroners' inquest in terms of timing and contact with the family.
- Aim to produce a report within 6 months of the DHR being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.
- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are fully explored.
- To discover if all relevant civil or criminal interventions were considered and/or used.
- To consider the risk and impact on the separation of children and the victim
- Determine if there were any barriers Ms White or her family/friends faced in both reporting domestic abuse and accessing services. This should also be explored against the Equality Act 2010's protected characteristics.

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

- Convene and chair an initial 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, co-ordinate and request IMRs.
- Review IMRs, incorporating suggested outline from the statutory Home Office guidance (where possible).
- Convene and chair a review panel meeting to review IMR responses.
- Write report (including Action Plan) or appoint an independent Overview Report author and agree contents with the Review Panel.
- Present report to the CSP (if required by the SSP Chair)

5 Domestic Homicide Review Panel

As listed in Appendix 1.

The above was confirmed at the first Review Panel meeting on 12 March 2020.

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

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

January 2020	Independent Chair appointed by Safer Somerset Partnership	
January 2020	Independent Chair establishes TOR and timetable with Safer Somerset Partnership	
March 2020	First Review Panel meeting IMRs/chronologies to commence	▪ ½ Day
March 2020	Liaison with Police, Coroner, relatives and friends	▪ 2 ½ Days
April/May 2020	IMRs (with chronologies) returned	▪ 2 Days (review by Chair) *
June 2020	Second Panel Meeting	▪ 1 Day
June/July 2020	Further interviews with family/friends	▪ 2 Days
July 2020	Draft report to be circulated via email.	▪ 3 Days (collation of report)
July/August 2020	Review Panel Meeting (to agree report and recommendations)	▪ 2 Days (including any final revisions of report)
August/ September 2020	Overview report to be submitted to the Safer Somerset Partnership Chair and signed off / sent to Home Office	▪ ½ Day

6.2 It is envisaged that this review will take the appointed DHR Chair no more than 13 ½ days (94.5 hours, as indicated above).

6.3 **The chronologies will be compiled by SCC to assist the Chair in analysis.*

7 Liaison with Media

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

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