Safer Somerset Partnership

Multi- Agency Domestic Abuse Death Review

Overview Report

Into the death of Laura in January 2018

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Independent Domestic Homicide Review Chair and Report Author

Report Completed: June 2019
Approved By Home Office January 2021

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1. Preface

1.1 Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be 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) A person to whom she was related or with whom she was or had been in an intimate personal relationship or
b) A member of the same household as herself; held with a view to identifying the lessons to be learnt from the death.

1.2 Throughout the report the term 'domestic abuse' is used in reference to 'domestic violence' as this is the term which has been adopted by the Safer Somerset Partnership.

1.3 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and agencies work individually and together to safeguard victims;
- 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;
- Apply those lessons to service response, including changes to policies and procedures as appropriate, and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working;
- Contribute to a better understanding of the nature of domestic violence and abuse;
- Highlight good practice.

1.4 This death was not caused by a homicide, instead death caused by dangerous driving. However, due to the offender being the deceased's current partner it met the criteria for a statutory review.

This review examines the circumstances surrounding the death of Laura in Somerset in January 2018 and is called a Multi- Agency Domestic Abuse Death Review. The principles underpinning the review process have been followed in accordance with the Home Office Multi-Agency Statutory Guidance on the Conduct of Domestic Homicide Reviews- Revised Version-December 2016.

1.5 The Independent Chair and the Review Panel members offer their deepest sympathy and condolences to Laura's family. The Chair would also like to thank the Review Panel who have contributed to the deliberations of the Review, for their time, honesty, transparency and cooperation.

1.6 The Chair of the Panel possesses the qualifications and experience required of an Independent Review Chair, as set out in section 5.10 of the Home Office Multi- Agency Statutory Guidance. She is not associated with any of the agencies involved in the Review nor has she had any dealings with either Laura or John and she is totally independent.

2. Multi- Agency Domestic Abuse Death Review Panel

- Faye Kamara LLB, MSc- Independent Chair
- Suzanne Harris, Somerset County Council
- Leanne Rowley, formerly known as Knightstone, now known as Live West from Autumn 2018 (provider of SIDAS-Somerset Integrated Domestic Abuse Service)
- Mark West, Avon and Somerset Constabulary
- Julia Burrows, Somerset Partnership NHS Foundation Trust (SomPar)
- Andrew Tresidder, Somerset Clinical Commissioning Group
- Victoria Wright, Somerset Clinical Commissioning Group

3. Introduction

3.1. This review examines the circumstances surrounding the death of Laura who was 34 years of age and had lived in Somerset for the last few years.

3.2 Laura was a talented artist and a mother to a child (named C for this review). Laura moved to Somerset in 2016 with her child and lived with her mother and stepfather. Laura had a diagnosis of rapid cycle depression and therefore had experienced a very up and down mood for most of her life. Laura also was diagnosed with severe dyslexia when she was 7 years old and therefore found reading and writing difficult even in adult life. Despite these vulnerabilities, family and friends described her as a fun-loving and kind person.

3.3 Laura and John (pseudonym) met whilst Laura was working in a local public house. They became friends at first and then this materialised into a relationship in November 2017. Family members were not happy by Laura's choice and made this clear to her, this was because John was connected, in the same social circle, to Laura's ex-partner.

However, Laura's family described her as being very smitten with John. C was introduced to John at the start of the relationship. Family reported as part of this review that C had taken a disliking to John and would say to them that 'he is going to hurt my mummy'. It is not completely clear why C had these opinions, however it is known that C overheard Laura and John having sex one evening in December which may have triggered these opinions.

3.4 In January 2018, it is reported by family members and friends that John had promised to take Laura and C out for ice cream in the local town one evening. Time passed into the evening and Laura found out that John had spent his wages in the public house getting drunk. Both Laura and C were upset by this and went to visit Laura's mother. Laura's mother offered to have C overnight so that Laura could go out and have some fun with friends after her disappointment. It was reported that Laura and John had been seen together that evening in the public house, appearing to be a couple.

3.5 Incident summary:

3.5.1 In the early hours of a day in January 2018 at 02.15hrs the ambulance service called the police to report that they were in attendance of what appeared to be a hit and run incident. A wallet was found at the scene containing a 'males' identity. A van registered to this male was then located with significant front-end damage, parked near to Laura's address. The male was identified as John of no fixed abode who was then later arrested.

3.5.2 Laura was declared deceased at the scene and her mother was notified that evening.

3.5.3 The Coroner opened and adjourned this case in order to allow for the criminal investigation to proceed. The Coroner closed this case at the point of conviction when the defendant pleaded guilty to death caused by dangerous driving and was sentenced to a term of imprisonment and was disqualified from driving.

3.5.4 The police investigated and charged John with murder/manslaughter. However, there was not enough evidence to support this charging decision and therefore this was amended to death by dangerous driving. John pleaded guilty to this offence and was given a custodial sentence for 10 years, reduced to 7.5 due to an early guilty plea.

3.6 The key purpose of this review is to enable lessons to be learned from Laura's death. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened,

and most importantly, what needs to change in order to reduce the risk of such a tragedy happening in the future.

3.7 The Review considers all contacts/involvement agencies had with Laura during the period January 2015-January 2018, as well as any events, prior to 2015, which are relevant to mental health, violence and abuse.

3.8 The Review Panel consists of senior managers, from both the statutory and voluntary sector, listed in section 2 of this report. All of the agencies who have been part of the Review have assisted in the identification of lessons and committed to implementing action plans to address the lessons.

3.10 The agencies participating in this Domestic Homicide Review are:

- Somerset County Council
- Somerset Partnership NHS Foundation Trust
- Somerset Clinical Commissioning Group
- Avon and Somerset Constabulary
- Knightstone Housing now known as Live West Housing (providers of SIDAS-Somerset Integrated Domestic Abuse Service)
- Taunton and Somerset NHS Foundation Trust

3.11 As per the Home Office guidance a letter together with the Leaflet on 'Domestic Homicide Reviews' was sent to Laura's family, Laura's best friend and John asking whether they wished to engage in this review. The independent Chair has met with Laura's family and spoke with her best friend. Laura's family approved the terms of reference and added a number of additional enquiries to this report including the exploration and support for family members who are worried about their loved ones in abusive relationships. John also made contact to understand more about the review via Probation and Prison services, however no further contact or information was then shared. Attempts were also made to contact C however these proved unsuccessful. Nevertheless, the intelligence from Laura's family and friends has been invaluable in understanding more about the circumstances surrounding this tragic death.

Laura's family also approved the final draft report before being submitted to the Home Office in June 2019 for Quality Assurance. The draft report was with the family for a number of weeks however no amendments were made upon return to the Chair. The family expressed at that time how they wished to be kept informed of the process before publication. Her family are in contact with AAFDA (Advocacy after Fatal Domestic Abuse) and plan to attend an event with this organisation in March 2020 which is about shared learning and peer support.

3.12 As per the Home Office guidance contact was also made with Laura's employer, however unfortunately there was no response from this organisation.

4. Parallel Reviews

4.1 There were and are no other statutory parallel reviews ongoing.

4.2 There was limited involvement from the Coroner however this is recorded in paragraph 3.5.3.

5. Timescales

5.1 On 22nd January 2018 Safer Somerset Partnership received a Domestic Homicide Review Referral relating to Laura from Avon and Somerset Constabulary. Following an initial exercise of information sharing with a range of agencies a decision was made by the Chair of the Safer Somerset Partnership to undertake a review.

5.2 An Independent Chair and Report Author was commissioned by the Chair of the Safer Somerset Partnership in June 2018 with the aim of completing this review by December 2018. It was noted at the first panel meeting (6th July 2018) that the criminal justice process has now concluded.

5.3 This review was not completed by the proposed deadline owing to, (1) a number of additional enquiries with agencies outside of the local area; (2) review of the report by Laura's family, and (3) virtual sign off of the final report between February 2019- May 2019.

6. Confidentiality

6.1 The findings of this Review are restricted to only participating professionals and their line managers, until after the Review has been approved by the Home Office Quality Assurance Panel. See section 18 for information on publication.

6.2 As recommended within the 'Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' to protect the identity of the deceased, and her family, the following pseudonyms in 6.3 have been used throughout this report.

6.3 The name Laura is used for the deceased, who was 34 years at the time of her death. The Independent Chair liaised with the deceased's mother and the name Laura was chosen by her. The name John for her most recent partner, C was used for the deceased's child, Henry for the child's father, William for another

ex-partner and Louise for her close family friend; all of these were all agreed by the Review Panel.

6.4 A redaction may simply replace a name with a pseudonym or may be the removal of personal and sensitive details about an individual, i.e. medical information. Redactions will not be used to protect the identities of the agencies participating in the Review.

6.5 The sharing of information between agencies in relation to the DHR was all underpinned by a Confidentiality Statement which each individual read and signed at the beginning of the review (Appendix B). An information sharing protocol was and currently is in place which all agencies represented on this panel are signatories to, this agreement is underpinned by the Crime and Disorder Act 1998 which the Safer Somerset Partnership have in place.

7. Dissemination

7.1 Each of the Panel members (see list at the beginning of report), the Chair and members of the Safer Somerset Partnership, the Avon and Somerset Police Crime Commissioner will receive copies of the Report. It will also be published online at the local Somerset domestic abuse website www.somersetsurvivors.org.uk. See section 18 for more details.

8. The Terms of Reference

8.1 Commissioner of the Domestic Homicide Review

8.1.1 The chair of the Safer Somerset Partnership has commissioned this review, following notification of the death (death by dangerous driving) of Laura in the county. The offender was her partner (John).

8.1.2 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.

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

8.2.1 Aims of Domestic Homicide Review Process

8.2.1 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.

8.2.2 To produce a report which:

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

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

8.3 Scope of the review

8.3.1 To review events up to the domestic abuse related death of Laura in January 2018. This is to include any information known about Laura's previous relationships where domestic abuse is understood to have occurred in order to establish whether Laura had been in a pattern of abusive relationships.

8.3.2 Events should be reviewed by all agencies for 3 years (i.e. January 2015) preceding the domestic abuse related death. However, if any agencies have any information prior to that they feel is relevant, then this should also be included in any chronology/IMR.

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

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

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

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

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

8.3.8 Agencies to explore what the response might have been should disclosures have been made by Laura. For example, would the GP practice have been confident to deal with a disclosure of domestic abuse?

9. Schedule of the Domestic Homicide Review Panel Meetings

First Panel Meeting- July 2018

Second Panel Meeting- August 2018

Third Panel Meeting- January 2019

Virtual conversations with Panel members to sign off final report between February 2019-May 2019.

10. Methodology

10.1 This Report has been compiled using information and facts from the following:

- Short factual reports/presentations from the following agencies;
    - Avon and Somerset Constabulary
    - Somerset Clinical Commissioning Group
    - Somerset Partnership NHS Foundation Trust
    - Live West Housing (formerly known as Knightstone) Somerset Integrated Domestic Abuse Service.

- A chronology of events leading to the death of Laura, coordinated and produced by Safer Somerset Partnership

- Discussions during the Review Panel Meetings;

- Conversations with family members and friends of Laura

10.2 Contact was also made by the Safer Somerset Partnership to Bournemouth Community Safety Partnership for information about Laura and C when they lived in this area. This was suggested by Laura's family. However, there was very limited information known about these two individuals by the agencies whom form part of the partnership.

11. Contributors to the Review

11.1 Whilst there is a statutory duty that bodies including, the police, local authority, probation and health authorities must participate in a DHR; in this case only four key agencies have voluntarily contributed to the review (listed in para 3.10) from the Safer Somerset Partnership. Albeit contact was made with other local authorities and police forces to understand more about Laura's history of relationships prior to 2017.

11.2 Family members and friends did respond to the invitation made by the Independent Chair to contribute to this review as previously advised in para. 3.11.

12. The Facts

12.1 Laura was described by her family and friends as a kind and fun-loving person. She was described by her mother as a 'fabulous daughter, sister and mother' to C. Laura grew up with her sister and mother for most of her childhood, and she did not have a relationship with her biological father. Laura's family advised that relationships with men became to form a pattern during her lifetime. Laura only moved in Somerset in 2015, prior to this she had lived in the Thames Valley area, Bournemouth and the outskirts of London during her childhood.

12.2 It was advised by Laura's family that when Laura was about 7 years old, she was diagnosed with severe dyslexia. Laura was therefore enrolled into a Special Educational Needs school and would get a taxi most mornings to school with other children. Family and friends reported that she always felt out of place because she wasn't disabled in any way.

This had quite an impact on Laura's behaviour, attitude and confidence within this school and therefore a decision was made to move her to a mainstream school to be with her sister and have additional one to one support in the classroom. Laura flourished in this school for a few years until her teenage years when her family advise she became more interested in socialising than education.

12.3 Laura's mother advised this Review that in 1991 she had a boyfriend who moved into the family home and that when Laura was about 8 years old, she found her boyfriend in bed with Laura- fully clothed and cuddling her from behind. Laura did not disclose that anything had taken place however Laura's mother was very upset by these actions and took the opportunity to educate her daughters on healthy and unhealthy relationships. Laura's mother also reported that the same boyfriend had also been physically and sexually abusive to Laura's mother and therefore she decided to end the relationship.

12.4 Laura's sister supported Laura to obtain employment as a lifeguard and Laura loved this work. She was able to progress to supervisor at one point in her career.

12.5 As a "girly break" from work, Laura went on holiday to Butlins with her sister when she was in her early 20s and met Henry (pseudonym). This wasn't Laura's first relationship however it quickly became serious when Laura found out she was pregnant and expecting C. Laura moved to Bournemouth to be with Henry and had C in 2008. Family reported that their 'honeymoon' relationship was short lived and not long after C was born Laura was advising her family that she was unhappy and that her relationship had broken down with Henry. When C was 18 months old Laura visited her family for the weekend and didn't return to Bournemouth.

12.6 Laura's family reported as part of this review that it was not unusual for her to be in a relationship which was abusive in some way; physically, sexually or emotionally manipulative. Laura entered a number of relationships over the years, all of which according to her family and friends were abusive in some way; usually emotionally abusive and manipulative.

On one occasion Laura did report to the police that she had been physically assaulted by her then current partner and harassed. This was when she was living in the Thames Valley area and Laura's family believe that her lack of confidence and vulnerabilities because she was dyslexic, desperately wanted a man in her life and her unstable mental health all contributed to the choices she made.

12.7 It is reported by Laura's family that she first sought help, advice and support from her GP in the London Borough of Hillingdon for her mental health in 2013. Family also advised that the medication she was prescribed to help her with her mood unfortunately made her gain weight and in turn made her feel very unhappy and lack confidence.

A referral was made by the GP to mental health services advising that Laura had been experiencing low mood for over a year which had been triggered by

a bad relationship with a boyfriend from a year ago, who stalked her for 4 months when they had split up. The GP also indicated on the referral that Laura had reported episodes of hypomania in the past when she became bankrupt having bought a new car despite already owning one. At that time in 2013, Laura disclosed that she felt paranoid about how people perceived her and responded to her with feelings of despair. She also stated she had periods of feeling very high and then suddenly very low.

12.8 Friends of Laura believed that Laura did need some long-term counselling to work through her emotions and experiences, this was offered to her whilst she lived in Buckinghamshire, according to medical records, however Laura chose not to engage.

12.9 In May 2015, it is reported in GP records in Buckinghamshire that Laura had terminated a pregnancy and was suffering from some abdominal pain. At this point she was also referred to a low-level mental health support service called Healthy Minds. It is unclear whether Laura engaged with this service.

12.10 In late 2015/early 2016 Laura's family moved from the London Borough of Hillingdon to Somerset and Laura and C followed them owing to being dependent on her mother. It was reported by friends that Laura did not want to leave the London Borough of Hillingdon due to her support networks and friends, however after a few months she was feeling more settled.

12.11 Laura attended or contacted a GP surgery in Somerset on a number of occasions between February- July 2016 owing to minor physical issues; ear infection, sore throat etc. However, in July 2016 Laura attended the GP surgery asking for birth control because she had a new partner and also advised she was suffering from anxiety.

12.12 About two weeks later Laura presented at the GP surgery again and disclosed that she was suffering from a depressive disorder and that she requested support. She was given a self-referral leaflet for Talking Therapies and prescribed Citalopram. She also disclosed as part of this consultation that she experienced historic issues of depression and advised that she had suffered from sexual and emotional abuse as a child from her mother's previous partner.

12.13 Any subsequent visits to the GP up until her death in 2018 were for physical issues and there is no record that she made any further disclosures of feeling mentally unwell or unstable or suffering from domestic abuse.

12.14 Laura's family and friends have advised that her partner prior to John was a man called William, whom she had met in the bar where she was working

during the summer of 2017. William had recently left his wife and three children, and Laura and he were only friends to begin with. Their relationship then became intimate for a short period. This changed when William arrived at Laura's address frothing at the mouth having taken an overdose. Laura contacted Williams's family and their relationship ended. Soon after this time Laura found out she was pregnant and had another termination in late 2017.

12.15 Similarly it has also been reported by Laura's family and friends that Laura met John at the same bar where she was working. Laura's friends believed that John had been having an affair with William's wife. Laura reported to her friends that she was not interested in John despite his flirtatious behaviour. Laura's family also warned Laura away from John given the close proximity to William and the small town they lived in. Laura's best friend was aware that John would drink in the bar and Laura would talk to Louise (pseudonym) about this. However, did not tell her that she began dating him in December 2017. Louise now believes this may be due to embarrassment because Laura was very aware of the choices she was making and how they may not always be the right ones.

12.16 Laura's family advised that her behaviour changed at Christmas time, she became distant and less engaged in family activities which was not like her usual character. Her family were aware that she was dating John and had disapproved of her choice. C, Laura's child, also overtly would say 'he is going to hurt my mummy- I know he is'. There was one occasion when C sent a text to Laura's mother saying that she could hear her mummy and John having sex. Laura mother advised Laura of this and Laura was very embarrassed.

12.17 It is reported by Laura's family that on an evening in January 2018, Laura and C were getting ready to be collected and taken out for ice cream by John because he had been paid and offered to do something nice for the two girls. Laura became aware that John had been in the bar all afternoon drinking alcohol and was very disappointed. Laura's mother offered to have C for the evening so that Laura could go into town and have a good time with friends given that she had got dressed up.

12.18 It is reported that Laura and John were seen together in the bar having a good time as a couple that evening. It is unclear why they left separately and why Laura had John's wallet in her possession. However, in the early hours of the next morning in January 2018, Laura was killed as a result of dangerous driving by John who was driving under the influence of alcohol.

12.19 Laura's family were advised of her death that morning.

13. Overview

13.1 The Panel have been committed to the Review, within the spirit of the Equalities Act 2010, and have demonstrated an ethos of fairness, equality, openness and transparency. The Panel have worked as a partnership in ensuring that the Review has been conducted in line with the Terms of Reference.

The Review has been cognisant of Laura's family and their privacy. Laura's family and friends were contacted as part of this Review to ascertain their views about Laura's lifestyle, interaction with agencies and her relationships. This intelligence has been invaluable given the little known by agencies in Somerset.

13.2 The practices of agencies were carefully considered to ascertain if they were sensitive to the nine protected characteristics of the Equality Act 2010 i.e. Age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, face and religion and belief, sex or sexual orientation.

In line with the Terms of Reference, the Panel considered these protected characteristics and concluded that although Laura had experienced episodes of poor mental health and had a diagnosis of dyslexia this did not make her disabled and therefore due regard was made throughout the report to these issues.

13.3 Internal reports were commissioned by the Independent Chair in July 2018; seeking evidence that where contact had been made policy and processes had been followed and where there hadn't been any contact- seeking assurance on what the response might have been.

13.4 A number of agencies/multi-agency partnerships/departments were contacted about this review initially in the Somerset area and Bournemouth Community Safety Partnership were also contacted.

13.5 Three agencies/partnerships from across Somerset confirmed that they had had some relevant contact with neither Laura nor John. They were:

- Avon and Somerset Constabulary
- Somerset Partnership NHS Foundation Trust
- Somerset Clinical Commissioning Group (not directly through GP practice)

13.6 The following two agencies were invited to take part in this review because of their expertise and role in improving responses to victims of domestic abuse and therefore they also provided a Panel member to this Review.

- Somerset Integrated Domestic Abuse Service
- Somerset County Council- Safer Somerset Partnership

13.6.3 Somerset Partnership NHS Foundation Trust is the main provider of mental health services in Somerset. Laura had not encountered this agency and John's involvement was also very minimal. However, given the mental health disclosures to the GP within Primary Care it was deemed appropriate to involve this agency.

13.6.4 Somerset Clinical Commissioning Group (CCG) is the main commissioner of health services within the Somerset area. The CCG have been included as part of this review in order to incorporate what was known by Laura's GP about her physical and mental health. It was known to Laura's GP surgery that she suffered from anxiety and depression in the past and therefore it was deemed appropriate by the Review Panel to include this agency to understand what support she obtained from this service to manage her mental wellbeing.

13.6.5 Avon and Somerset Constabulary provide the police service to the county of Somerset. Laura was not known to this agency. John was known for one domestic incident with a previous ex-partner and some other minor offences. It was deemed relevant to involve this agency to understand whether there should have been any disclosures and what the response might have been. Also, to understand in this case the rationale behind the charging decisions for Laura's death.

13.6.6 Somerset Integrated Domestic Abuse Service is the specialist domestic abuse support service in Somerset commissioned by the local authority (Somerset County Council) to provide the core services of IDVA, outreach and accommodation. Laura did not have any contact with this agency prior to her death.

13.7 A chronology was compiled as part of this review given the number of contacts Laura and John had had with these agencies. A brief summary of this is captured in 'The facts' section of this report.

13.8 All reports and presentations were completed by professionals who were independent, and had no contact with either Laura, the offender or any direct line management of any professional who had contact with them.

14. Analysis

14.1 The Panel has considered the internal reports through the viewpoints of both Laura and John, to ascertain whether the contact made had been appropriate

and that the agency acted in accordance with their set procedures and guidelines in order to establish whether any lessons needed to be learnt. In addition, the reports were to also cover where there hadn't been contact- what would have been the response.

14.2 The authors of the Internal Reports have followed the Review's Terms of Reference and addressed the points within it. The agencies undertook the Internal Reports in an honest, thorough and transparent fashion, ascertaining information from a number of sources. The following is the Review Panel's view on the appropriateness of the intervention undertaken by each agency and/or whether their policy and procedures are adequate in protecting and supporting victims of domestic abuse.

Somerset Partnership NHS Foundation Trust

14.3 As previously articulated in this report, this organisation did not have any contact with Laura, and contact with John was very limited because he chose not to engage. A referral was made by John's GP to the local Talking Therapies service. It is not known why this referral was made because access to John's medical records have not been made due to patient confidentiality.

However, it is known that contact was very limited and there was no engagement by John following this referral being made. The referral was incomplete and there was almost a two-week delay in this being followed up with the GP by the Talking Therapies team, and then a further 10 days delay in the additional information being sent to the mental health service by the GP. It was one month after the initial referral was made that attempted contact was made.

14.4 The Panel debated whether the timeliness in John's referral being processed had an impact on this review and concluded that it did not, on the basis that we are unsure how much and why John felt he wanted and needed support from a mental health service. It was reported that self-referrals for Talking Therapies by patients are far more likely to engage than referrals into the service that are made by GPs or other agencies.

14.5 The Panel discussed the referral processes into the Talking Therapies service and agreed that GPs should be reminded of the referral pathway in order to avoid further delay and prevent disengagement with the patient due to time lapsed. This has been actioned as part of a GP bulletin.

Somerset Clinical Commissioning Group

14.6 It was reported within the Internal Report commissioned by the Independent Chair and by the author as part of the Panel meeting that Laura had registered in Somerset with the GP practice only at the end of 2015 and therefore there was minimal information. However, during the two years Laura had a number of contacts with the GP; some for physical health concerns; sore throat etc. and there were two consultations' in quick succession where Laura disclosed issues with her mental health and was proactively seeking support, advice and help from the GP.

There was one consultation where she did disclose historical abuse however there is no evidence in her records that her current relationship status was explored. The Panel felt that professional curiosity, particularly in relation to relationship status in the context of exploring domestic abuse was something that should be included in safeguarding training for all healthcare staff.

14.7 The Internal Report highlighted these two contacts, both of which occurred in the summer of 2016. The Panel debated whether it was deemed appropriate to give a patient with severe dyslexia a leaflet for a service they needed and which puts the onus on them to make the referral themselves. The Panel accepted that there is a greater engagement rate where patient's self –refer, and the Panel felt assured that the leaflet was in easy to read format. Nevertheless, this did also trigger another learning point, in that the GP supporting and treating Laura in Somerset did not appear to know Laura's history from previous GP surgeries where she had disclosed periods of low mood and suicidal thoughts before.

Laura's records indicate that the information surrounding her dyslexia were not available and therefore it is highly likely that the Somerset GP was not aware of this learning difficulty. Clinically the diagnosis was debated by the Panel also because there was no 'flag' on Laura's records or history. There was only one mention of this in a mental health assessment which was undertaken when she was a child.

Therefore, the Panel concluded that due to multiple GP practices caring for Laura over the years, the information in her history was not successfully transferred between GP practices in succinct summary form in order to support a new GP in their role of providing care to her as a new patient. Had this been the case then perhaps greater intervention would have been offered for Laura upon these two attendances by the GP. This short summary would have to have been initiated by Laura though because this is not routine practice and unless the patient advises the current GP that they intend to register elsewhere they will not be aware of such change.

14.8 It is clear from the contact Laura had with the GP practice that this was empathetic and supportive. The Panel questioned whether a PHQ-9 form had been undertaken upon her attendances reporting low mood in order to track her feelings of depression and anxiety. This questionnaire is a tool used in primary care called Patient Health Questionnaire 9 item, in order to establish the presence and severity of anxiety and depression.

This is not a mandated action on GPs when a patient discloses feelings of this nature, however is a resource available to them. The Panel felt in this case that it was not a missed opportunity that one was not completed with Laura, however a follow up appointment to see how Laura was feeling after her second attendance in August 2016 would have been good practice.

Avon and Somerset Constabulary

14.9 This Internal Report was undertaken using a range of methodologies to research for information about both parties during the three-year period as per the Terms of Reference. Very limited information was held about either party until the incident in January 2018. The internal report was transparent, and actions taken in relation to the aforementioned incident were critiqued well. Consideration was given to the contact this organisation had with John because there had been a previous domestic incident reported to the police by an ex-partner of John. This incident involved damage to their jointly owned car and was correctly identified as a domestic incident and treated as such.

Unfortunately, there was little cooperation by either party in order to complete a DASH Risk assessment nevertheless the intention was there to undertake this. The Panel agreed that these were appropriate actions and that an analysis of the previous domestic incident was entirely reasonable.

14.10 The actions undertaken by this organisation after the fatal incident resulting in Laura's death were also analysed as part of this review. The Internal Report and Panel both agreed that actions undertaken to investigate how Laura died were robust and reasonable.

Appropriate procedures were initiated following attendance at the scene and priority enquiries were progressed around identifying the victim and notifying the family as well as identifying and arresting the offender. The family also supported this comment that Avon and Somerset Constabulary investigated Laura's death well.

14.11 Another line of enquiry which was explored by this organisation related to Laura's involvement with any other police forces because it was reported by her

family that she had been in a number of abusive relationships some of which had had police involvement; this was carried out with respect to the Terms of Reference in para 8.4.1.

One domestic incident was reported to another police force in 2012 by Laura. She reported that she was being harassed by her ex-partner, whom she also added had been abusive to her during the relationship also. Policies and practices have changed and much improved since 2012 therefore the actions taken were not analysed in great detail. However, the Report Author and Police representative felt that this incident was dealt with appropriately; a DASH completed in a timely manner, a harassment warning issued, and a follow up conversation was had with Laura 6 weeks after the initial report to see how she was and whether she had received any contact from the person in question.

14.12 This organisation did not make any recommendations as a result of this review. Their policy and procedure had recently been reviewed following another domestic homicide review and the Panel felt assured that this reflected all of the latest guidance, research and legislation.

Somerset Integrated Domestic Abuse Service

14.13 This organisation did not have any contact with either party. The Panel were keen to understand more about the prevalence rates of domestic abuse reported incidents/referrals into this service within the area where Laura lived. This district was the third highest rate of referrals compared to the other areas that make up the county of Somerset.

Staff working for this service were asked as part of this review to comment, using their professional knowledge, on whether there were any agencies within the district where Laura lived whom required domestic abuse awareness training. They concluded by advising that all agencies were working well together in this district to reduce the harm caused by domestic abuse and that no additional domestic abuse awareness training was necessary.

15 There was one theme which was discussed by the Panel. This was the pattern of abusive relationships which Laura had with various males during her lifetime. Her family advised, as part of this review, that she was a vulnerable individual owing to her mental health and lack of confidence and seemed to attract the same kind of person. The Panel discussed how anecdotal evidence from local services shows that perpetrators of domestic abuse appear to sometimes spot these signs in individuals, and the relationships become abusive because they like to exert their power and control on the person who is vulnerable. This appeared true for Laura.

According to Laura's family she also did not have a high level of self-esteem because they felt this had been torn down by her previous abusive partners. It is true that someone who has had their self-worth taken away is more likely to believe they deserve what their partner chooses to do, or that they are so unlovable, no healthy partner will ever want them (The National Domestic Violence Hotline, 2019). As already highlighted it is sometimes the case that perpetrators appear to recognise this trait. The Panel therefore concluded how important it is to raise awareness of domestic abuse and the impact abusive relationships can have on self-confidence for the short and longer term.

16 Conclusions

16.1 In reaching their conclusions the Review Panel have focussed on the following questions;

- Has the Panel fulfilled the Terms of Reference for this review by undertaking a variety of lines of enquiry, including discussing the draft chronology and entering broader more strategic discussions about cross authority working?
- Will the actions and suggestions for improvement improve the response domestic abuse victims have in the future?
- What are the key themes or learning points from this review?

16.2 The Review Panel are satisfied that the Terms of Reference have been fulfilled and that discussions did take place at the Panel meeting to consider what was known prior to Laura's death in January 2018.

16.3 The Panel is of the opinion that the agreed recommendations appropriately address the points raised throughout the review, particularly in relation to the lessons learnt and the theme discussed.

16.4 The Panel felt that there were a number of key issues which were fundamental to the discussion and therefore key learning points. Firstly, the fact that Laura's mental health history was not available and therefore could not be taken into consideration by the GP because it was not included in a short summary as a new patient and her medical records had not arrived at the Somerset practice.

This meant that a strategic position and her chronological history was not available to be explored when she attended the practice with low mood and anxiety. The Panel accept that this would not have prevented her death however it might have helped how she felt in terms of wellbeing, support networks and her confidence and how the GP supported her moving forward.

16.5 Another key discussion point related to the pattern of Laura's abusive relationships according to her family and how society can best support those who continue to enter into these. Consideration was also made on how services should be in place for perpetrators to help break the cycle of abuse. As a county Somerset have a strong domestic abuse partnership which consists of a range of agencies whom work together to improve the responses to victims of domestic abuse. A voluntary perpetrator programme was noted to have been in place in Somerset since 2006.

The Panel, as representatives of this partnership, reflected on how well they are trying to raise the awareness and educate society about abusive relationships. This led to an agreement that more could be done to raise awareness of the signs of domestic abuse and that specialist support is available to help not only leave an abusive relationship, but to regain self-esteem to avoid entering into one abusive relationship after another. Also, there should be improvements in how abusive behaviour should be identified, challenged and support be in place for those perpetrators needing help to change their behaviour.

Laura's family also overtly have asked as part of this review if there could be more awareness of what support family members can offer their loved ones whom they believe are in abusive relationships. Somerset County Council through their "Somerset Survivors website" noted that they have produced a 'family and friends' booklet' which offers advice to family and friends who suspect their loved one maybe in an abusive relationship. Nevertheless this was not known to all members of the Review Panel illustrating that the knowledge surrounding this issue was not embedded hence the recommendation. The Panel supported the view that more awareness was necessary in relation to professionals and the community understanding the risk factors associated with domestic abuse and more importantly where individuals can go for advice and support.

17. Recommendations

17.1 NHS England with support of Somerset Clinical Commissioning Group

17.1.1 Discussion to be had, with the assistance of the Chair of this review, regarding medical records and how high-level medical history can be shared with a new GP practice as soon after registration has taken place to ensure the continuation of the patient's care appropriately.

17.2 Safer Somerset Partnership

17.2.1 Consideration to be given to an awareness campaign focusing on the pattern of abusive relationships and how individuals can access support to end this cycle of one abusive relationship after another. (It was suggested by the Panel that this could be the theme for Domestic Abuse Awareness Week in November 2019)

17.3 Somerset Integrated Domestic Abuse Service

17.3.1 This agency, with the support of the domestic abuse partnership, to raise awareness of their services for family members and friends whom are worried about their loved ones being in an abusive relationship. And to promote the availability of the 'family and friends' booklet' at www.somersetsurvivors.org.uk

17.4 Additional Panel recommendations

17.4.1 Safer Somerset Partnership to lead in supporting the Safeguarding Somerset Adult Board to disseminate the learning from this review to all agencies involved in safeguarding vulnerable people.

17.4.2 Safer Somerset Partnership in support with the Domestic Abuse Board to seek assurance in asking all agencies to provide evidence that they include professional curiosity in their safeguarding training. This is in particular the exploration of an individual's relationship status when there is any disclosure of abuse; historical, recent or current.

18. Postscript

18.1 Actions to be taken after presentation of the Overview Report to the Safer Somerset Partnership

18.2 The partnership should:

- Agree and sign off the content of the Overview Report for publication, ensuring that they are fully anonymised, apart from the names of the Review Panel Chair and members.
- Provide a copy of the Overview Report and supporting documents to the Home Office Quality Assurance Group. This should be via email to DHRENQUIRIES@homeoffice.gsi.gov.uk
- The document should not be published until the partnership has received confirmation from the Home Office that the report has passed the Quality Assurance process.

18.3 On receiving clearance from the Home Office Quality Assurance Group, the Safer Somerset Partnership should:

- Provide a copy of the Overview Report and supporting documents to the senior manager of each participating agency.
- Publish an electronic copy of the Overview Report (this must be carefully redacted) and Executive summary on the Safer Somerset Partnership website
- Monitor the implementation of the specific, measurable, achievable, realistic and timely (SMART) Action Plan.
- Formally conclude the review when the Action Plan has been implemented and consider an audit process
- Make arrangements to provide feedback and debriefing to staff, family members and the media as appropriate.

Appendix A

Bibliography

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David Warren. 2015. 'Project to collate learning from the Domestic Homicide Review that have been completed across Avon and Somerset in order to improve the safety of individuals affected by domestic abuse' Final Report – Avon and Somerset Violence Against Women and Children Group. Available from: http://www.avonandsomerset-pMiss D.gov.uk/Document-LiMr Cary/Reference/DHRreview.pdf

Pieces of legislation

Adoption and Children Act 2002

Crime and Disorder Act 1998

Domestic Violence, Crime and Victims Act 2004

Equalities Act 2010

Serious Crime Act 2015

Care Act 2014

Protection from Harassment Act 2002

Appendix B

Confidentiality Statement

Somerset Domestic Homicide Review into the Death of
Laura

CONFIDENTIALITY AGREEMENT

– PLEASE READ THIS DOCUMENT CAREFULLY

This document must be read and signed by all members of the DHR Panel.

If you have any questions concerning this document, please contact your manager before signing. You should retain your own-signed copy for future reference.

Many of the services that agencies in the Somerset area provide for its clients are confidential and to enable them to perform these services, its clients disclose confidential and personal information to those involved in their care and assistance.

The goodwill and respect of these agencies depends amongst other things upon keeping such services and information confidential. You may have access to such information, see or hear information of a confidential nature during your involvement in the DHR Panel.

You are not permitted at any time during or after your involvement in the DHR Panel to disclose any such personal or business information whatsoever including to colleagues and line managers. In holding information, you occupy a position of trust which you are required to respect. Any breach of confidentiality will be viewed seriously and could result in termination of your contract.

You will need to observe the very basic rule that information revealed, and Panel discussions are confidential. It should not be discussed with anyone except when written permission has been sought from and granted by the Chair. In no circumstances should you discuss it with family, friends, other clients, the general public or in any public place. In addition, you are not permitted to or allow any

unauthorised person/s to examine or to make copies of any reports documents or business information to do with clients or the business of this DHR. Any information you hold should be deleted or handed back to the Chair at the end of the Review. Disclosure may be in breach of the Data Protection Act and may give rise to irreparable injury to the clients as the owner of such information; and they may seek remedy against the agency where you employed.

If you are in any doubt about the disclosure of any information **you should consult the Chair**.

I confirm that I have read and understand the above. I understand that any breach of this confidentiality will be regarded as a serious matter by the Chair and Somerset CSP and may result in legal proceedings.

NAME:

SIGNATURE:

AGENCY:

DATE: