OVERVIEW REPORT

of the

Domestic Homicide Review

relating to the unexpected death of Lily in 2019

on behalf of:

The Safer Somerset Partnership

Report Author: **Liz Cooper- Borthwick**

Independent Chair

Report submitted to Home Office: April 2022

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GLOSSARY

ABBREVIATION	DEFINITION
AFV	Adult Family Violence
ASC	Somerset Adult Social Care
CCG	Somerset Clinical Commissioning Group
CMHT	Community Mental Health Team
DHR	Domestic Homicide Review
HTT	Home Treatment Therapy
IAU	Incident Assessment Unit
IDVA	Independent Domestic Violence Advisor
IPV	Interpersonal Violence
KPE	Key Practice Episode
LSU	Lighthouse Safeguarding Unit Lighthouse Victim Care
MARAC	Multi-Agency Risk Assessment Conference
MHSW	Somerset Adult Social Care Mental health social worker
OIC	Police officer in charge of Investigation
SSP	Safer Somerset Partnership
SDAS	Somerset Drug and Alcohol Service provided by Turning Point
SIDAS	Somerset Integrated Domestic Abuse Service
SARSAS	Somerset and Avon Rape and Sexual Assault Service

SARC	Sexual Abuse and Rape Counselling
SOMFT	Somerset Partnership NHS Foundation Trust
SWASFT	Southwest Ambulance Service Foundation Trust.

1.0 PREFACE

1.1 This Domestic Homicide Review (DHR) examines agency responses and support given to Lily and her family before Lily's unexpected death in June 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 Lily'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 Domestic Abuse Act 2021 defines domestic abuse as:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

(a) A and B are each aged 16 or over and are personally connected to each other, and

(b) the behaviour is abusive.

(3) Behaviour is "abusive" if it consists of any of the following—

(a) physical or sexual abuse;

(b) violent or threatening behaviour;

(c) controlling or coercive behaviour;

(d) economic abuse (see subsection (4));

(e) psychological, emotional or other abuse;

and it does not matter whether the behaviour consists of a single incident or a course of conduct.

[1] DHR-Statutory-Guidance-161206.pdf(publishing.service.gov.uk)

(4)"Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—

(a)acquire, use or maintain money or other property, or

(b) obtain goods or services.

(5) For the purposes of this Act A's behaviour may be behaviour "towards" B even though it consists of conduct directed at another person (for example, B's child).

(6) References in this Act to being abusive towards another person are to be read in accordance with this section.

(7) For the meaning of "personally connected," see section 2.

1.2.2 Definition of "personally connected"

(1) For the purposes of this Act, two people are "personally connected" to each other if any of the following applies—

(a) they are, or have been, married to each other;

(b) they are, or have been, civil partners of each other;

(c) they have agreed to marry one another (whether the agreement has been terminated);

(d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated);

(e) they are, or have been, in an intimate personal relationship with each other;

(f) they each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2));

(g) they are relatives.[2]

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. [3]

The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person died because of domestic violence and abuse. For these

[2] Domestic Abuse Act 2021 www.legislation.gov.uk
[3] Controlling or Coercive behaviour HO guidancehttps://www.gov.uk/government/publications/statutory-guidance-framework-controlling-or-coercive-behaviour-in-an-intimate-or-family-relationship

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.

1.3 THE REVIEW

1.3.1 Lily's death did take place in **mid- 2019** and at the time the SSP was not notified about a potential DHR. In 2020, following Somerset County Council Public Health reviewing deaths by suicide, and notifying the SSP of Lily's death to consider for a DHR, the SSP concluded that Lily's death did meet the criteria for a DHR, and an Independent Chair was commissioned to carry out a DHR.

1.3.2 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.

1.3.3 The panel met **six times** during the period **February 2021 to January 2022** (All meetings were virtual due to covid-19 pandemic restrictions, but this method made no difference to the commitment of the Independent Chair or the DHR Panel and it was felt that attendance at the Panel meetings were enhanced due to the participation in virtual meetings).

1.3.4 Following receipt of the Individual Management Reviews, the DHR Panel considered whether Lily's case also met the threshold of a **Safeguarding Adult Review (SAR)[5].** A referral was made to Somerset Safeguarding Adult Board (SSAB) with the response that they would not be commissioning a SAR but would request that learning from the DHR should be shared with SSAB.

1.4 Time scales

1.4.1 The review began **February 2021** and concluded with submission to the Home Office in **February 2022.** The DHR did take around twelve months to complete and this was due to the impact of Covid 19 on agencies, especially health which meant that resources to produce IMR's and further information were limited and therefore time frames were adjusted accordingly.

1.5 Confidentiality

[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf
[5] Safeguarding Adult Review. https://ssab.safeguardingsomerset.org.uk

1.5.1 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.

The DHR has been anonymised in accordance with the statutory guidance. The specific date of the homicide has been removed. Only the Independent Chair and the Review Panel are named.

The following pseudonyms have been used to protect the victim and other family members.

Name	**Relationship to Victim**
Lily	Victim
Peter	Partner of Lily and alleged perpetrator of domestic abuse
Gary	Son of Lily and Gerry and alleged perpetrator of domestic abuse
Tom	Son of Lily and alleged perpetrator of domestic abuse
Gerry	Deceased husband of Lily and father of Gary.

Safer Somerset Partnership wish to express their sincere condolences to the family and friends of Lily.

2. Terms Of Reference

Terms of Reference were agreed by the DHR Panel and were regularly reviewed and amended as further details of Lily's life emerged. The full terms of reference are attached in Appendix One. The DHR aims to identify the learning from Lily's death and actions with a view to preventing unexpected death and ensuring individuals and families are better supported.

The Review Panel was comprised of agencies from Somerset as this was the area that the victim lived. Agencies were contacted as soon as the DHR was established to inform them that their participation was required and that records needed to be secure.

At the first panel meeting, the Review Panel considered the initial scoping as conducted by the SSP. It was agreed that the period of the review would be 1 May 2016b until the death of Lily, spring 2019. This was intended to cover the period from a police force recorded incident between Lily and her son.

If agencies were involved with lily or her family prior to xxx and the information was significant to the review, they were asked to include in their IMR.

The key lines of enquiry for this review were as follows;

a) 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 following are fully explored:
    - the dynamics of coercive control
    - the understanding of domestic abuse and links with mental health and substance misuse
    - knowledge and awareness of familial abuse (rather than between intimate partners)
b) To discover if all relevant civil or criminal interventions were considered and/or used.
c) Determine if there were any barriers Lily 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.
d) To discover whether agencies complete safety plans for people who are self-harming/suicide risk and to what extent people are encouraged and /or supported to complete self-held safety plans.
e) To consider professionals perceptions around a victim/perpetrator behaviour which may have impacted on support for the victim (Confirmation bias).
f) Did professionals use their "professional curiosity "skills to understand the needs and know the victim better

3. METHODOLOGY

Contributors to the Review

3.1. Statutory and Voluntary Agencies:

Each involved agency submitted an Individual Management Review (IMR) in accordance with the statutory guidance. 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 Clinical Commissioning Group (on behalf of the GP)
iii. Somerset Partnership NHS Foundation Trust (SOMFT)
iv. Somerset Adult Social Care (ASC)
v. Somerset Integrated Domestic Abuse Service (SIDAS)
vi. Southwest Ambulance Foundation Trust (SWAST)

3.1.2 Somerset Drug and Alcohol Service (Turning Point) were requested to complete an IMR but on reviewing their records they found no details of Lily or any family members. Although Lily had made an initial contact with SDAS just prior to being discharged in **May 2019**, there was no record on file of this contact as Lily was just provided with initial information.

3.1.3 Lily and her family lived in social housing and information was provided by the registered provider (RP), Livewest about their contact with Lily and the family. Information provided identified they had no information relating to any anti-social behaviour. Lily contacted the RP around maintenance issues of the property.

3.1.4 Somerset County Council Public Health mental health lead was invited to be a member of the DHR panel and provided specialist expert advice and challenge about suicide and suicide prevention.

3.1.5 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.

3.2 Involvement of Family and Friends

3.2.1 The Independent Chair wrote to the Lily's two sons (Gary and Tom) and the sons were provided with the Home Office DHR family leaflet and details of advocacy organisations. but there has been no contact. Despite efforts to obtain contact details for Peter, Lily's partner, no information was found and therefore no contact has been possible. Information provided did identify that Lily had a sister and the Independent Chair did contact Lily's sister, but she confirmed that she did not wish to participate in the review. Tom, Peter and Lily's sister were spoken to as part of the SOMFT Root Cause Analysis Investigation (RCA) and the final report, with their comments being shared with the Independent Chair and included in the DHR.

3.2.2 Although the police stated that Lily was well known in her community, this was a very general statement and due the family not wishing to speak with the Independent Chair is has not been able to identify any friends or neighbours within the community.

Although the sister of Lily did not want to participate in the DHR, she did say that she was happy for her comments from the RCA to be used.

3.3 Research and contacts by the Chair

Lily had had a history of multiple attempts at self-harm and overdoses (totalling 42 overdoses from the age of 20 years old, a period of around 30 years) and to understand what support was available and is now available to support people who are vulnerable to suicide the Independent Chair spoke directly with the Public Health Specialist (Public Mental Health and neighbourhood Programme), Somerset County Council in order to understand the facts and figures around death by suicide in Somerset and to understand the support services that are now available in Somerset.

Although Lily did not engage with Somerset Drug and Alcohol Service (SDAS) directly, the SDAS Safeguarding Manager remained as a DHR Panel member to provide challenge and expertise about substance abuse which was relevant to this DHR.

4. PANEL MEMBERSHIP AND REPRESENTATIVES

The Panel consisted of senior representatives from the following agencies.

NAMED OFFICER	ORGANISATION	ROLE
Liz Cooper-Borthwick	LCB Consulting	Independent Chair
Suzanne Harris	Somerset County Council and Safer Somerset partnership	Senior Commissioning Officer (Interpersonal Violence) Somerset County Council
Samuel Williams	Avon and Somerset Police	DCI- Major and Statutory Crime Review Team
Andrew Tresidder	Somerset Clinical Commissioning Group	Lead General Practitioner - CCG
Emma Read	Somerset Clinical Commissioning Group	CCG Lead Safeguarding Nurse
Louise White	Somerset Adult Social Care (ASC)	Adult Safeguarding Service Manager Somerset County Council

Louise Finnis	Somerset County Council Public Health	Public Health Specialist, Public Mental Health and Neighbourhood programme

5. Statement of Independence

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 is a member of the AAFDA DHR Chair Network and participates in training to support her continuous professional development (CPD). Liz has also been involved with several Serious Case Reviews(children and adults). Liz has no connection with any of the agencies in this case.

6.0 PARALLEL INVESTIGATIONS AND RELATED PROCESSES

6.1 Inquest

At the time of writing, the coroner has not yet listed Lily's death for an inquest. *(To note the Independent Chair has liaised with the Coroner's Office for updates.)*

6.2 Somerset NHS Foundation Trust (SomFT) Root Cause Analysis Investigation Report

Following Lily's death SomFT conducted a level 2 Serious Investigation into events during Lily's final admission to hospital and post discharge. SomFT agreed to disclose the report to the Independent Chair and any relevant information has been included in the DHR and has helped to identify any lessons to be learnt.

(*To note that when Lily was receiving support up until her death, she received support from Somerset Partnership NHS Foundation Trust (mental health and community health trust) known as Sompar. In April 2020 Sompar merged with Taunton and Somerset NHS Foundation Trust (acute hospital) to form a new Trust known as Somerset NHS Foundation Trust (SomFT). The merger enabled the delivery of joined up community health, mental health, and acute hospital care for the people of Somerset. Within this report the mental health agency responses are referenced to SomFT)*

7.0 EQUALITIES

7.1 Lily was heterosexual white British woman.

7.2 Peter is a heterosexual, black man (no further details of race have been possible to identify)

7.3 Gary is a white British man

7.4 Tom is a white British man

7.5 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). Three of these characteristics are considered to have had an impact – sex/gender, disability and race. This characteristic is considered later within this report.

The DHR Panel identified that very few of the agency IMR's included the ethnicity of the victim or perpetrator(s) and therefore a learning action for agencies was that "professionals need to be reminded that they should record ethnicity in case notes" and include when requested for an IMR. This has also been included as a recommendation as detailed in section 16 of this report.

8.0 Dissemination

8.1 The Overview Report, Recommendations and Executive Lily have been redacted to ensure confidentiality, with pseudonyms used for the victim and the family. The report has 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. Domestic Abuse Commissioner for England and Wales

9.0 BACKGROUND INFORMATION

9.1 Details of the Incident

9.1.1 The police were called to Lily's house mid-June 2019 to find that she had jumped from a bedroom window. The ambulance service arrived and tried to resuscitate Lily, but they were not able to. Lily had bruising around her neck and shoulder but no other injuries to suggest she was a victim of an assault**.** There were no criminal

proceedings. The police were challenged by the DHR Panel about the assumption that Lily jumped and was not pushed. The police stated that statement were taken and the evidence highlighted that Lily jumped.

9.1.2 **Post-mortem**

A post-mortem was carried out following Lily's death which concluded death by

I. T7 spinal fracture and spinal cord injury in combination with a chest injury with rib sternal fractures and,
II. Acute toxicity of fluoxetine. The case remains open pending inquest

9.3 Subjects of the Review

The main subjects of this review are:

DHR subjects	**Age at time of death**	**Ethnic Origin**	**Disability**
Lily **(Deceased victim of domestic abuse and alleged perpetrator of domestic abuse)**	54 years old	White British	None registered
Peter **(Lily's partner, perpetrator of domestic abuse and possible victim)**	46 years old	Black	Not known
Gary **(Child of Lily and Gerry alleged perpetrator of domestic abuse and victim of domestic abuse)**	25 years old	White British	Not known
Tom **(Child of Lily and alleged by Lily to be a perpetrator of domestic abuse)**	35 years old	White British	Not Known
Gerry (Husband of Lily)	Deceased		

10.0 THE CHRONOLOGY

10.1 Background information on victim and alleged perpetrators.

10.1 With no information provided by the family, the background on Lily and her family has been taken from agency IMRs and other documentation made available to the Independent Chair including SomFT Root Cause Analysis Investigation.

10.2 Information provided by SomFT indicates that Lily's childhood experience could have been quite difficult, her mother was diagnosed with schizophrenia[6] and her father allegedly died by suicide.

10.3 In growing up within the family household, Lily may not have been given the empathy and nurturing during her childhood which may have impacted on her wellbeing and decision making in adult life.

10.4 Lily had a significant history of mental health issues dating back to at least 1998. Lily was diagnosed with Emotionally Unstable Personality Disorder[7] (more commonly known as borderline personality disorder (BPD)) and mental and behavioural disorder due to the misuse of amphetamines[8] and alcohol.

10.5 Lily was previously married to Gerry for around 25 years until he died in **2016**. Lily had two sons, Tom, from a previous relationship prior to Gerry and Gary who was Gerry and Lily's son. Gerry also suffered mental health problems and there were a number of domestic incidents between Gerry and Lily documented on police records. Lily was arrested three times for battery against Gerry of which one proceeded to trial in **2011**, but Lily was not found guilty. Gary was present or involved in several of their arguments with Lily being arrested twice for battery against Gary in **2011** and **2015**. **The 2015** incident did proceed to trial but was withdrawn as Gary was not prepared to attend. The case in **2011** was referred to a Multi-Agency Risk Assessment Conference with Lily being identified as the perpetrator and Gerry the victim. This incident that took place in **2015,** there is no information of this going to a MARAC or

[6] Schizophrenia, a mental disorder characterised by continuous or relapsing episodes of psychosis, symptom include hallucination, delusion, paranoia and psychosis , social withdrawal and decreased emotional awareness.www.nhs.uk/schizophrenia.
[7] BDP- wide range of symptoms, grouped within 4 areas, emotional instability, disturbed patterns of thinking, impulsive behaviour and intense but unstable relationships with others.
[8] Amphetamines-Stimulant drugs which make the brain and body move faster. Powerful stimulator of central nervous system but highly addictive.www.medicalnewstoday.com

why a victimless prosecution did not take place. "A victimless prosecution" is one where no evidence is directly adduced from a complainant. This is only likely to take place where a victim is a) unwilling to give evidence, and b) it is in the public interest to continue without the victim).[9]

10.6 Gerry died by suicide in **February 2016** whilst a mental health hospital inpatient. Gerry's death seems to have been difficult for Lily to accept and Lily told agencies of her unhappiness and her struggle with grief following Gerry's death. There is no information within any of the IMR's that Lily was offered any grief counselling or signposted to relevant support.

10.7 Following Gerry's death, Lily lived with Gary and Tom lived on and off with Lily and Gary and Lily met Peter in **2017/18**.

10.8 As the family did not engage with the DHR the voice of the victim has been identified through IMR's and further historical information from agencies, e.g., SomFT

10.9 Information provided identified that Lily's mother was a schizophrenic and her father had mental issues resulting in a death by suicide. The experiences in Lily's childhood may have not given Lily the skills to navigate the many traumas she experienced through her life.

10.10 Lily was a very vulnerable person and well known in her community. When Lily's husband, Gerry, died told professionals how much she missed him and was so sad and lonely without him.

10.11 Lily did engage with agencies and sought help when she felt it was needed. (A sign of strength in Lily.) Lily appears to have been a good tenant, contacting her housing provider about maintenance of her property (Lily being proactive) and the relevant housing authority reported that they had no records of any antisocial behaviour. . The police did have several reports of anti- social behaviour with Lily as both the victim and suspect but there is no evidence to suggest that this information was shared with the housing authority.

10.12 The DHR Panel felt the information provided suggested Lily was lonely and wanted friendships and guidance.

10.2 Chronology- The Facts

[9] www.allaboutlaw.co.uk- why does the CPS pursue cases even without victim support

10.2.1 The information below has been drawn from a range of sources; the IMRs submitted by agencies (referenced where appropriate). IMR authors were requested to review agency contact with Lily. Peter, Gary and Tom for **May 2016 up until Lily's death.** The reason for this period was to reflect the relationship between Lily and Peter. Agencies were also requested to include any other contact prior to **May 2016** if it was significant and added further evidence to the DHR. The IMR have been reviewed and robustly challenged by the DHR Panel.

10.2.3 Significant information has been made available for this review and the DHR Independent Chair has utilised the SCIE model "Learning together" [10] to identify the key episodes in the lives of Lily, Peter, Gary and Tom in the lead up to Lily's unexpected death.

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

- **KPE One: Allegations of familial abuse**
- **KPE Two: Allegation of sexual assault on Lily**
- **KPE Three: Lily's mental health and escalation of alcohol use**.
- **KPE Four: Further deterioration of Lily's mental health and alleged familial abuse**
- **KPE Five: Escalation of domestic abuse, interpersonal and familial**
- **KPE Six: Lily's admission to hospital**
- **KPE Seven: Lily's death**

10.3 Key Practice Episode One – Allegations of familial abuse between Lily and Gary (2016)

10.3.1 16 May 2016, Lily called 999 to report that Gary had repeatedly punched her in her face. On arrival, Officers found that Lily was very intoxicated, she could barely stand, had very slurred speech and no visible injuries. Lily told the police that she had taken some of Gary's rum and that he became angry. Gary had gone to his girlfriend, but the police spoke to Gary some days later and he told them that he suggested Lily should not drink the rum as she was already intoxicated. No further action was taken by the police as there was insufficient evidence. An officer perceived DASH (which was rated medium) was completed as Lily was too intoxicated to complete a victim led DASH. The officer at scene felt that Lily had not been hit, she had no visible injuries

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

consistent with her account. The case was reviewed by an inspector who was satisfied that the case did not meet the criteria for charging. A Domestic Violence Protection Notification (DVPN)[11] was considered but there was no evidence or threat of violence, so this was not pursued. Lily was referred to Lighthouse Safeguarding Unit (LSU)[12] as is standard practice for domestic abuse incidents. The referral was not progressed as there was no evidence of assault and no identified victim. *(Source; Police IMR)*

10.3.2 Lily visited her GP on **24 May 2016** as she had lower back pain, the GP referred Lily to a physiotherapist, but she also asked for morphine. The GP stated it was not appropriate to have morphine. On the **31 May 2016**, Lily phoned the GP practice reception to discuss medication dosage and saying she had felt suicidal the evening before and had taken a higher dose than usual of her medication. Lily said she felt much better. The reception gave Lily an out of hours phone number for the practice and mental health services if her mood deteriorated. *(Source CCG IMR)*

10.3.3 The police were contacted again by Lily on **11 June 2016** to report an attempted burglary from her shed. A neighbour also contacted the police **14 August 2016** about ongoing harassment by Lily, but the neighbour did not want to take things further, so the police gave advice on blocking of phone numbers. *(Source: Police IMR)*

10.4 Key Practice Episode Two – Allegations of Sexual Assaults on Lily (Autumn 2016)

10.4.1 Lily called the police on **24 September 2016** to report one historic sexual assault which had happened some months prior to **September 2016** and a second historic sexual assault which took place around **9 September 2016** was reported by Lily to the police on **28 September 2016** . Lily said the assaults were by a man only known by his nickname and the other Lily did not know his name. Lily stated she was too drunk to have given consent to the men. Both incidents were investigated but Lily would not engage with the police and stated that she no longer wanted to pursue the complaint. The case was closed. *(Source; Police CCG SomFT IMR)*

The Police did make a referral to Adult Social Care, but the outcome of the referral was not noted on the system. There is no information provided by the Police as to whether Lily was referred to Somerset and Avon Rape and Sexual Abuse Support (SARSAS)[13] or Sexual Assault Referral Centre (SARC)[14].

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[11] Domestic Violence Protection Order -Emergency Non- Molestation and Eviction Order. www.gov.uk-Domestic Violence Protection Notices Guidance.
[12] Lighthouse Safeguarding Unit -Team formerly responsible for supporting victims and witnesses of crime, supporting onward referrals to other agencies and, where appropriate .
[13] Somerset & Avon Rape and Sexual Abuse Support www.sarsas.org.uk
[14] Sexual Assault Referral Centre

10.4.2 The police followed procedural guidance for sexual assault and determined that an Achieving Best Evidence (ABE) interview would be appropriate. The police liaised with the relevant mental health team to ensure that the plans for the interview would be appropriate for Lily's metal health and vulnerabilities. Despite contact with Lily, she felt unable to keep appointments with the Officer in Charge (OIC). *(Source; Police IMR)*

10.4.3 Lily had a face-to-face consultation with her GP on **26 September 2016** as she requested an examination having had the two episodes of being sexually assaulted when under the influence of alcohol. Lily explained that the police were involved. The GP carried out an examination to check on Lily's health. *(Source CCG IMR)*

10.4.4 On the same day, Lily called the police following a further argument with Gary regarding his contact with Lily's sister. During the call Lily was shouting and swearing. The police did attend Lily's home but there were no signs of a disturbance . Lily did disclose that she was suffering borderline personality disorder and struggling with alcohol and sleep problems. Lily confirmed she had professional support through a Community Psychiatric Nurse (CPN). A DASH was completed by the police and was rated standard. No offence was disclosed so the police took no further action. *(Source ;Police IMR)*

10.4.5 **2 October 2016**, Somerset Adult Social Care (ASC) received a request for information from the police regarding concerns for Lily. The Care Coordinator from SomFT contacted the investigating police officer and arranged to see Lily. The contact was picked up a couple of weeks later as the Care Coordinator was absent, but the Community Mental Health team made plans to assess Lily.

10.4.6 The joint assessment with the Care Coordinator was delayed until **9 December 2016** as Lily had missed appointments. Lily was very sleepy during the appointment and explained she was feeling low as she had run out of her anti-depressants. Case notes identified that Lily had no housing issues, but the Care Coordinator made a referral to the village agents[15] for support and inclusion. ASC case recorded that no further input was required. *(Source; ASC IMR)*

10.5 KPE Three - Escalation in Lily's mental health and substance abuse. (Early 2017)

10.5.1 **9 January 2017** the ambulance was called as Lily had fallen, cut her face and was dazed. *(Source; SWAST IMR*)

[15] Village Agents are provided by the Community Council for Somerset. Village agents provide confidential, community-based solutions. Referrals can be direct or via a GP

10.5.2 **13 January 2017**, Tom phoned the police to say that he had been contacted by Lily's sister to say Lily was drunk and had taken pills and was threatening to cut herself. Lily was found by police officers at her home address drifting in and out of consciousness. Lily was taken to A&E by the ambulance service. Lily was discharged and the GP tried to make a follow up call on **18 January 2017** but there was no response from Lily. *(Source; Police, CCG and SWAST IMR)*

10.5.3 Following Lily's discharge from the local hospital, ASC carried out a review of Lily's needs on **15 January 2017**. The discussion included risk factors and protective factors, mental state and a crisis plan. ASC contacted the village agent to say that Lily would benefit from activities in the community and that she liked art. *(Source; ASC IMR)*

10.5.4 Lily called SOMFT and the police on **17 February 2017** to report a threat made by Tom made , sometime in **December 2016**. Lily said that Tom had threatened to take Lily to some local hills and burn her. Lily also said that Tom had assaulted her in the past. After an investigation it was agreed that Gary would speak with Tom and ask him to cease contact. SomFT contacted the police to share their concerns they had for Lily and provided the police with up-to-date information around Lily's health. *(Source; Police and SomFT IMR)*

10.5.5 Lily was referred by SOMFT into the Mental Health Social Care service on **15 April 2017** with the recommendation that she should be encouraged to engage with community groups. *(Source; ASC, SomFT IMR)*

10.5.6 **27 March 2017,** Lily called the police to report that Gary was angry and was banging on her bedroom door accusing her of taking drugs and not letting her leave her room. During the call, Lily said that Gary bullied her and controlled her life including how she spent her money. Gary also made a call at the same time. The incident was filed as a verbal argument with no further action. *(Source; Police IMR)*

This incident could indicate that Gary was trying to control Lily including her finances, an example of controlling coercive behaviour and economic abuse or that he wanted to prevent Lily from taking drugs (amphetamines) and the family did not know how to help Lily with her drug use. The IMR author identified that a DASH was not completed although the IMR author has highlighted that DASH compliance is now extremely high within the Police (latest data (92.4% compliance). Although at the time there is no evidence as to whether the alleged controlling coercive behaviour by Gary was explored, the police have taken the steps to ensure Officers can recognise coercive control more readily and take time to pursue further lines of enquiry when indicators

of coercive control are evident when dealing with domestic incidents. A specific CCB procedural Guidance has been developed and is shortly being published.

In addition, the police have recognised the need to continue to improve its response towards DA and will be delivering DA Matters programme later in 2022. The programme is aiming to effect mass cultural change through police force health checks, training the majority of first responders to DA, creating DA Matters Champions and train local trainers so training is ongoing). A copy of the DA Matters programme is attached in appendix Two.

10.5.7 **4 June 2017**, the Ambulance service was contacted as Lily was having difficulties in breathing.

10.5.8 **11 November 2017**, the police received a 999 call from a newsagent reporting that a female, Lily, had attempted to buy alcohol and she was refused because she was banned for an alleged theft from the shop. Lily threw the bottle and made threats to the newsagent as she was upset because she was refused service.

10.5.9 The police referred the victim (store assistant) to LSU and Lily was arrested at home and taken into custody and the police sergeant decided that Lily required an appropriate adult[16] for the interview. Whilst in custody, Lily was seen by a nurse and the police sergeant released Lily home as in his opinion it was not appropriate to detain a mentally vulnerable person overnight whilst waiting for an appropriate adult to become available. The OIC contacted the specialist Mental health hospital to identify an appropriate adult and to check Lily's capacity to be interviewed. The specialist mental health hospital identified that Lily was not a patient at this time and felt she should account for her own actions and was fit to be interviewed. The information provided does not confirm whether the contact with the specialist mental health hospital was within the timescale of Lily being in custody. *(Source; Police and SomFT)*

*(Lily was charged with common assault and criminal damage and was convicted in **February 2018** and received a conditional discharge of one year.)*

10.5.10 **21 November 2017**, Lily attended the A&E department feeling unwell with a disturbed mental state behaviours she was having delusions and hallucinations. The Psychiatric Liaison Team at the hospital contacted the ASC Approved Mental Health Practitioner hub stating Lily had presented at A&E in a very odd manner. It was stated that Lily had been trying to stab herself with a pen knife and that her life had become quite "chaotic" in the context of her continuing grief and underlying issues relating to

[16] Appropriate Adult is to safeguard the interest , rights, entitlement and welfare of a child or vulnerable adult. www. Appropriateadult.org.uk

her husband's death. Lily was referred to a psychiatric team for a Mental Health Act Assessment. *(Source; SWAST, ASC IMR)*

10.5.11 On the same day, Lily was scheduled to have an interview with the police, but Lily did not attend due to the incident above. *(Source; Police IMR)*

10.5.12 Lily was interviewed relating to the incident on **11 November 2017** on the **4 December 2017** and she admitted throwing the bottle but that she felt suicidal. The OIC conducted a risk with Lily in the presence of an appropriate adult and ensured Lily had the contact details for the mental health crisis team. The Police were not aware of the earlier hospitalisation (**21 November 2017**) during the interview. (*Source; Police IMR)*

10.5.13 Nine days later **30 November 2017**, the police received a 101 call to report concern for a female (Lily) who the caller thought was trying to jump into the river in her local town. The police attended and noted that Lily appeared calm and collected and she said that she had been drinking most of the day. Lily was taken home and no further action was taken. (*Source; Police IMR)*

10.5.14 Lily visited her GP again in **June 2018** regarding her mental and behavioural disorders due to psychoactive substances. The GP and Lily discussed her past mental health issues and noted that Lily had not taken amphetamines for a few months and had not drunk alcohol for a few weeks. The GP recorded that Lily looked quite cheerful. *(Source; GP IMR)*

10.6 Key Practice Episode Four – Further deterioration in Lily's mental health and further allegations of familial abuse (Mid 2018)

10.6.1 **4 July 2018**, Lily called 111 with suicidal thoughts and consent was given by Lily to sharing her electronic record with her GP. The records indicated that Lily had been drinking alcohol every day lately but had not drunk today so she was shaking and feeling delirious and panicky. Leaflets and bereavement support was given, and Lily was signposted to SDAS. It was made clear to Lily that she could contact the crisis team if needed. *(Source; CCG IMR)*

10.6.2 Lily called 999 on **13 July 2018** and spoke to the police stating that she was being held against her will by Peter and Gary. The call handler spoke with Peter and Gary during the call who said they thought Lily was having a significant mental breakdown. Lily was heard crying and saying "I need help" but then she left the property.

10.6.3 The following day the police contacted the control room Mental health Triage and informed the mental health services that Lily had contacted them to report that

Gary and Peter were preventing her from leaving the house. The police stated that they had spoken with Peter and Gary, and they had denied the accusation, but they also raised their concerns about Lily's mental health. The information provided by the police was shared with the mental health professionals working with Lily and the police were informed about an appointment Lily had, scheduled for **25 July 2018**. *(Source; Police , SomFT IMR)*

10.6.4 **16 July 2018**, Lily called the police to report that Gary had pushed her over , punched her and stopped her seeing friends. The police attended and spoke with Lily at a friend's house. The police officer noted that Lily was not making any sense, but she confirmed she found herself on the floor in the street and that she thought Gary had pushed her over. A DASH was completed, and the risk was rated as medium. Officer did speak with Gary under caution, and he denied assaulting Lily, stating that he had received a call saying Lily was causing a scene in the street. When Gary found Lily, she was laying in the road, and he pulled her from the road as he was concerned that she would get run over. Later, Lily told the police officer that she assumed she had been assaulted as she as on the ground, but she now thought it was a mental health episode. The police officer advised Gary to contact Lily's GP, but Lily said she had an appointment with the specialist mental health hospital, nine days later. *(Source: police IMR)*

10.6.5 Lily had her outpatient appointment with a psychiatrist following the GP referral on **25 July 2018.** Lily told the psychiatrist about her increased depression, increased back pain and increased amphetamine use which were contributing to relationship difficulties. Peter was also present at the appointment. (*Source; SomFT IMR)*

What is not clear or evident is whether Lily's back pain was a bigger issue for Lily than agencies had understood. Did professionals consider that Lily may have drunk and took drugs to manage her pain.

Lily spoke of her grief around the loss of Gerry and again it would appear that professionals did not consider Lily's use of alcohol and drugs as a coping mechanism for her grief.

10.7 Key Practice Episode Five – Escalation of reports of domestic abuse by Peter and Gary. (Late 2018)

10.7.1 Lily called the ambulance on **28 October 2018** to say she had been punched in the face the night before, but she refused to name the person and did not disclose any domestic abuse. The Ambulance service contacted the police to request support on standby if the offender was still with Lily. The ambulance took Lily to hospital. When the police attended Lily's home three days later, Lily did have a bruise under her eye,

but she refused to identify the offender. The police did carry out house to house enquiries, but no further evidence was obtained, and the incident was closed.(*Source Police and SWAST IMR*)

Lily gave further information about this incident on 19 December 2018 (See paragraph 10.7.5)

10.7.2 **23 November 2018,** an ambulance was called as Lily had taken amphetamines was struggling to breath and had fallen out with her partner. Lily disclosed domestic abuse to the ambulance crew who made a safeguarding referral to the police. The GP received a letter from SomFT explaining that Lily had presented to A&E seeking respite due to relationship difficulties and anxiety. The letter went on to explain further that Lily had been alluding to suicidal ideation and that it was suspected that there was a heavy amphetamine use and withdrawal from alcohol which may have caused increased anxiety and distress. *(Source; SWAST,SomFT,GP IMR)*

(There was no record of any safeguarding referral from SWAST on any police records).

10.7.3 Lily called 999 on **26 November 2018** and said that Gary was behaving aggressively towards her. Lily said she had been out walking the dogs when one had run off, this had angered Gary and he became aggressive. Lily also reported that Gary had punched her in the head a month earlier. Lily was asked if she felt threatened in anyway and she said no. The police noted that Lily had no signs of injuries and did not want to pursue the complaint and the case was closed. (*IMR; Police, SOMFT and SWAST*)

The police noted that Lily showed no signs of injury but the incident she spoke about happened a month earlier and it is conceivable that any physical injury could have healed so the assumption by the police that there was no physical evidence of abuse does not prove the alleged assault by Gary did not take place. There was an opportunity to explore the incident further, interview Gary and review the risks and safety planning for Lily.

10.7.4 Lily was visited the following day by the police. Lily did not want to complete a DASH, so an officer perceived DASH was completed. The DASH was rated as standard, but the Incident Assessment Unit (IAU) completed the classification of the review and reviewed the other incidents in **July** 2018 and **October 2018**. The IAU noted Lily's mental health concerns and that this would make her more vulnerable and a potential victim of domestic abuse including controlling coercive behaviour. The IAU asked LSU to review their engagement with Lily and determine if she needed more support. The IMR author noted that the IAU were diligent in their classification review, identifying the possibility of controlling and coercive behaviour. *(Source; Police IMR)*

10.7.5 Lily phoned 999 again on **17 December 2018** and the call handler heard a disturbance on the call and then Lily abandoned the call. Officer attended and Lily said she had called by accident, but she did disclose that an argument had taken place where she had called Peter "a gorilla" which he did not like, and he poked Lily on the cheek. In response Lily struck his thigh with a frying pan. It was agreed with Lily those officers would speak with her later to see how she wanted to progress the complaint. Lily told the police that she called Peter a gorilla not because of the colour of his skin but because of his body language. *(Source; Police IMR)*

The DHR Panel had a debate around the language used above which was detailed in the IMR's from agency records. Poked and struck were used by professionals and the choice of language could infer that an action was not serious although agencies felt in the context of this review the wording was appropriate, but it was noted that professionals should be reminded about appropriate language use in recording an incident.

10.7.6 The Police call handler received an abandoned 999 call on **19 December 2018** with the sounds of a male and female arguing. Police officer attended and Lily alleged that Peter had put a cigarette butt out on her arm and that Peter had assaulted her around **28 October 2018**. Lily also reported sexual abuse by Peter. The Police interviewed Lily and Peter separately in line with procedural guidance. Following an investigation, the allegation of a sexual assault was filed with no further action as no offence had been disclosed. With regards to the assault, it was concluded that both Lily and Peter's accounts were plausible with no evidence supporting one account over the other. As there was insufficient evidence, the police made the decision to close the case with no further action. Peter then made counter allegations against Lily, saying she had scratched him. On the same day, Peter was arrested and taken into custody. Lily said she had video footage of the incident on 19 December 2018 and the officers with Lily reviewed the footage but there was no evidence of injury or damage although there was an argument recorded between, Lily, Peter and Gary. A DASH was completed with Lily and the risk was rated medium. During the discussion with the officer, Lily disclosed a picture on her mobile dated **30 October 2018** of her bruised arm which she reported was caused by Peter, grabbing her and pushing her to the floor as she would not help construct a bed. Lily confirmed she went to hospital due to the pain in her arm and back.

10.7.7 Lily confirmed that Gary was present during the argument and the policed planned to interview him, but Lily also told the police that she was regularly subjected to verbal and physical abuse by Gary. Lily disclosed that she had been assaulted by Gary on **28 October 2018** and she was punched in the head resulting in an ambulance

taking her to hospital. Lily told the police that she was upset and acting hysterical because Peter assaulted her on **28 October 2018** whilst building a bed. This angered Gary and so he punched her in the head as hard as he could. Lily told the police she did not report the incident to the police and that she told hospital staff that two unknown males had assaulted her. A victim led DASH was completed with the risk generated as standard. The officer increased this to high with a Treat as Urgent marker placed on Lily's address and Lily was advised should Gary return to the house. Officers tried to arrest Gary at his place of work as confirmed by Lily but there were no records of Gary ever being employed at the place of work described by Lily. Following investigation by the police it as thought that Lily changed her account to allege that Peter was the perpetrator. As Peter was being investigated for the assault on **17 December 2018**, Gary was not interviewed, and the incident was filed with no further action on **22 December 2018.** The police decided that Gary was not a credible witness and therefore would not be interviewed. . The police completed a victim led DASH which was rated as medium. Officers visited Lily later the evening of 19 **December** to take a witness statement and Lily was offered an Achieving Best Evidence[17] Interview (ABE) but declined. In Lily's witness statement, Lily agreed that there was no non-consensual sexual activity, made allegations of controlling coercive behaviour by Peter but admitted that she burnt herself with the cigarette butt. Lily was not specifically asked about the assault by Gary on **28 October 2018.**

10.7.7 Peter was interviewed about the incidents on **28 October 2018**, **17 December** and **19 December 2018** and Peter did offer alternative explanations. Peter denied trying to control Lily but said that there were trust issues between them. Peter was released and returned home to Lily with her agreement. The police sergeant advised that a Domestic Violence Protection Notice (DVPN)[18] should be considered to prevent further offences and reduce the risk to Lily who was identified as vulnerable. Evidence identifies that a DVPN was not applied for and there is no documented reason as to why not.

It is not known why the DVPN was not applied for. If the reasons were documented this would have provided an audit of why a certain decision was made and could then have been reviewed and challenged to inform learning in the future.

10.7.8 On each occasion a referral was made to LSU and the LSU attempted to contact Lily on three occasions. In connection with the assault by Peter. No safeguarding referrals were made as Lily did not meet the criteria. Following the incident on **19**

[17] Achieving Best Evidence Interview (ABE) ABE in Criminal Proceedings -Guidance on interviewing victims and witnesses-Ministry of Justice. www.cps.gov.uk

[18] Domestic Violence Protection Order, Police serve an alleged abuser od DA with a DVPN, it last 48hrs and the alleged perpetrator cannot contact the victim. www.ncdv.org.uk

December 2018 and the retrospective report of an assault on **28 October 2018** the LSU made an onward referral relating to the incidents **28 October 2018** and **19 December 2018** to SIDAS and an IDVA was assigned to Lily. The LSU did refer Lily into the MARAC despite the automatic threshold not being reached but based on professional judgement. The date of the LSU referral was around the **20 December 2018**. *(Source; Police, SIDAS IMR)*

10.7.9 Following Lily's witness statement, the IOC for the assault noted that Lily had changed her account in her statement and said she was assaulted by Peter and not Gary. A MARAC Co-ordinator reviewed the incident on **17 January 2019** and determined that the Lily would not be referred to the MARAC due to the uncertainty of the identity of the subject.

10.7.10 The police received a call from Lily on **11 January 2019,** having become involved in a verbal argument with Peter whilst out shopping. During the call, the call handler could hear Peter becoming verbally aggressive in the background, whilst Lily explained what was happening. Lily abandoned the call, but the police officer did go to the shop, but Lily and Peter had gone home. The police visited Lily and Peter at home, and both confirmed that they had been involved in a verbal argument. As there was no offence the incident was filed, and no further action was taken. An officer perceived DASH was completed and rated as standard and the IAU reviewed the classification and requested an LSU referral to be considered as the argument was a domestic argument involving Lily who had previously been involved in domestic incidents, but this was not progressed as the incident had been filed. *(Source; Police and SIDAS IMR)*

This was a missed opportunity to support Lily and for the police to make a referral to a MARAC based on professional judgement.

10.7.11 Lily called the police again on **4 February 2019** as she has had an argument with Peter. The police attended and spoke to Lily and Peter separately and established no offence had occurred. Peter had accused Lily of taking Base [19](a drug) and she had become upset. Peter agreed to leave for the evening. A DASH rated Standard (little input from Lily as she was angry that Peter was leaving) and a detailed BRAG rated amber were completed. The BRAG noted that Lily might need a mental health assessment and that Peter would benefit from some support. Peter told the police officer that there was a pattern of some stable behaviour by Lily followed by more challenging weeks. The police made an LSU referral, but no onward referrals resulted. On considering the onward referral, the LSU determined that Lily did not meet the

[19] Base is a stronger ,powdered version of amphetamine known as speed. www.drugwise.org.uk

threshold for adult social care and Lily's metal health issues were noted but the police believed there was no direct pathway for the police to refer Lily to mental health services or substance misuse services. (There appears not to have been the consideration to use the Somerset Safeguarding Adult Board What to do if it is not Safeguarding partnership model).[20] *(Source; police, IMR)*

10.7.12 **11 February 2019**, Lily's son contacted the GP as he was concerned about Lily's Apnoea[21]. The GP had a consultation with Lily, and she was referred to a sleep clinic and there was an examination of her chest and oxygen saturations were taken. A further appointment was arranged with Lily to review her medications and weight in more detail. *(Source; CCG IMR)*

10.7.13 **29 March 2019**, Lily had a face-to-face consultation with her GP to review general aches and pains and analgesia was prescribed for Lily's aches and pains. *(Source; CCG IMR)*

10.7.14 A third party called the police on **31 March 2019** and reported that two females were shouting and arguing in the street. On arrival at the scene Lily was drunk and erratic and Lily was arrested for common assault. Lily was taken into custody and was detained until she was sober and to allow enquires to made about disclosure Lily made about having sex with a fifteen-year-old boy the previous day. Officers spoke with the child whilst with his father. The father explained that Lily had been drinking with him and the boy's mother. The father said that Lily was very drunk, and she asked to have sex with their son. Whilst in custody Lily was seen by a medical health practitioner and the drug and alcohol service but she declined a full assessment. Lily told the police she was sorry she fabricated the allegation of sex with a young boy. Lily was released from custody. *(Source; Police IMR)*

10.7.14 Lily called the police on **8 April 2019** to say that the child's mother and another person were calling her a paedophile and making threats of violence. Lily continued to call the police throughout the day reporting that stones were being thrown at her house and the bin being kicked over. The police visited **Lily 9 April 2019** and took a statement and Lily was referred to the LSU who tried to contact her but were unable to. *(Source Police, SIDAS IMR)*

10.7.15 **8 May 2019** Lily was admitted to hospital due to an intentional drug and alcohol overdose and a cut wrist and Lily said she wanted to kill herself. (Source and SWAST IMR)

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[20] www.safeguardingsomerset.org.uk – Practice guidance, "What to do if it's not safeguarding"
[21] Apnoea- Sleep apnoea is when breathing stops and starts while you sleep. www.nhs.uk sleep apnoea

Lily was admitted to the relevant hospital and assessed by the Psychiatric Liaison Team on **9 May 2019** and was discharged with ongoing support from the Home Therapy Team (HTT) with the aim to stabilise Lily from reaching full crisis point.

10.7.16 **13 May 2019**, the HTT visited Lily at home and the risk of self-harm was reviewed as low and support and advice was given around alcohol issues. Lily said she has been abstaining from alcohol since the overdose. Following the visit , the HTT contacted the police to report Lily's allegations of harassment by a neighbour. Over the next few days, HTT tried to make welfare checks with Lily, but they were unable to gain a response. *(Source ;SOMFT IMR)*

10.8 Key Practice Episode Six - Lily's admission to hospital. (Late Spring 2019)

10.8.1 Tom called the HTT on **22 May 2019** saying that Lily's health was deteriorating and requesting "to have Mum sectioned". Lily then called the police, reporting that Peter and Tom were being abusive to her, saying she was taking drugs and she wanted them to leave the house. Lily then put the phone down. Tom, then phoned the police who said that Lily was being aggressive and violent to him and Peter. Tom said he thought Lily had taken an overdose and that he had contacted the mental health crisis team that day as he was concerned about her behaviour. Lily refused to speak with the team and therefore nothing had happened to support Lily. The police completed a DASH which was rated as standard. Lily became very erratic, and the police called an ambulance and the mental health crisis team to update them about Lily. Lily was admitted to the specialist ward on **24 May 2019.** (*Source Police, CCG, SOMFT, SWAST IMR)*

10.8.2 On being admitted to the ward, Lily did say that she felt disturbed as she was admitted to the ward her husband had ended his life on, three years earlier. (*Source; SOMFT IMR)*

10.8.3 Over the next few days, Lily was kept under observation and was reported to be interacting well with staff and other patients. Lily's antidepressant programme was reviewed, and a short detox programme was advised. Lily appeared to proactive with the support, taking her medication, taking walks and being bright and polite with staff. Information identified that Lily was visited in hospital by either Tom or Gary and one of the sons asked staff if they could attend the next ward review (cannot confirm whether it was Tom or Gary). (Source ;SOMFT IMR)

10.8.4 A ward review did take place on **4 June 2019** involving the consultant , Lily and her son. Lily did voice her suicidal thoughts and that she would be likely to access drugs and amphetamines if she left the unit. It was recorded that Lily was anxious and agitated at the meeting. The following day , with the support of staff members , Lily

phone Somerset Drug and Alcohol Service to say she would need to contact them on discharge from hospital. Lily completed a lifestyle questionnaire with an Occupational Health Therapist and that identified she was not feeling in control of her life or feeling good at this moment in time. *(Source ; SOMFT IMR)*

10.8.5 Lily had a review with the consultant on **7 June 2019** at which they spoke about social stressors prior to admission to hospital and her fears about being accepted at home. There was a discussion about the need for Lily to work with SDAS and that her addiction as impacting on her mental health. Lily was told that her discharge date would be 11 June 2019.

10.8.6 **8 June 2019** Lily called 101 from the ward. Lily told the call handler that her husband had hung himself three years ago whilst on the ward and she believed he was murdered by staff. Lily said she was concerned for her safety and thought that she may be murdered. There were no police units available to attend to make enquiries about Lily's claim. The call handler accessed guidance from their supervisor. The supervisor told the call handler that the allegation should not be assumed to be false just because it was from a patient on a mental health ward. The call handler checked the circumstances for Gerry's death and decided not to call the ward as it was not clear what risk this would create. The police asked the Mental Health triage to review the log on **9 June 2019** and the police were advised that Lily was an informal patient and could leave at any time, but they declined to provide any further information on Lily's psychiatric history stating it was not relevant. (Source Police IMR)

10.8.7 On the same day , one of Lily's sons called the ward to say he was concerned about the plans to discharge Lily. He said he thought that Lily would try to end her life if she came home, and he requested that this information be provided to the consultant. There was no record that this information was past to the consultant. *(Source; SOMFT IMR)*

10.8.8 Later in the evening, Lily spent time in the communal areas of the hospital, and it was noted that her behaviour was odd, and she was argumentative with staff. The following day a handover notes from staff reported that Lily had been sexually harassing a member of staff. Staff did not feel that the recent changes in Lily's behaviour were of a psychotic nature.

10.8.9 Lily and the hospital ward phoned Lily's son on **10 June 2019** to say that Lily would be discharged on 11 June 2019. The son said that he had received calls from Lily over the weekend and that he felt she was not ready for discharge. Later in the day, staff reported that Lily was acting in an odd manner reporting she was disclosing

abstract things in her thinking. Lily did attend an art class but as the day progressed, she became more confrontational with staff and fellow patients.

10.8.10 The ward team discussed Lily's behaviour and felt it was not due to any substance misuse or psychosis but her anxiety of leaving the hospital the next day. *(Source SOMFT IMR)*

10.8.11 **11 June 2019**, a discharge meeting was held with a doctor and Lily. Lily appeared accepting of her plan to go home and that she would try to not overdose and would seek help from SDAS.

10.8.12 Lily was discharged from the ward after lunch and went home by taxi.

10.8.13 Tom called 999 to say Lily had been drinking, was having psychotic episodes and was acting very weird. Tom said that Lily had run naked into the street but had now returned and Tom was concerned that Lily would harm herself. Tom had tried to contact the ward but was unable to speak with anyone. The police advised Tom to call an ambulance and to call the mental health crisis team and to keep calling Glanville House. Later in the afternoon Tom spoke with a doctor on the hospital ward and discussed the rapid change in Lily's behaviour and her drinking since leaving hospital. The doctor explained to Tom that SDAS would support Lily in the future although SOMFT services would still provide support as required.

10.8.14 Information provided by SDAS confirms that although contact was made by Lily from hospital it was not a referral, it was a conversation around services offered. Tom said he would stay at a friend's house that evening as he felt he may make the situation worst but that Peter. Lily's partner would be with her overnight. (*Source SOMFT IMR)*

10.9 Key Practice Episode Seven - Lily's death (Early summer 2019)

10.9.1 The following day, the police received a call from Peter saying that Lily had jumped from a bedroom window. The call handler talked Peter through CPR until the ambulance arrived. The Police followed the sudden death procedures, secured the scene, and made house to house enquiries. Peter gave an account under caution and the police told Gary and Tom that their mother had died. An investigation was carried out and the police were satisfied that Lily's death was not suspicious, and the investigation was closed. (*Source Police and SWAST IMR)*

11.0 BACKGROUND INFORMATION/ENGAGEMENT WITH FAMILY AND AGENCIES

11.1 Summary of Information Provided by family and friends.

As already described in the section "Contributors to the Review" section 3.2 , the family did not wish to engage in the DHR review, although information provided by the family to the RCA has been included in this review.

11.2 Summary of Information provided by Agencies.

11.2.1 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 Lily, Peter, Gary and Tom up until the date of Lily'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.

11.2.2 Avon and Somerset Police IMR (the police)

11.2.2.1 Avon and Somerset Police (the police) had many contacts with Lily (43) of which thirteen incidents involved some alleged domestic abuse. Lily was well known to the local neighbourhood police team and response team with records showing an extensive history of domestic abuse and mental health issues. Police records identified that Lily had a history of violence and a propensity to make false allegations.

11.2.2.2 The police carried out a DASH summary of 13 domestic incidents including;

- 6 Victim led DASH (2 Std, 3 Med, 1 high).
- 5 Officer perceived DASH (3 Std, 2 Med) of which 3 were due to Lily being intoxicated , angry or refused , 2 no documentation reason for officer perceived DASH rather than victim led.
- 2 No DASH (On attendance, the incident was determined to be mental health related and not domestic abuse and Lily became hostile to the presence of officers, requesting everyone to leave (Incident 27 March 2017).

11.2.2.3 The Police attended Lily's home on numerous occasions even if she abandoned the call. The Police recognised the need to establish any safeguarding concerns. During the incidents on **17 December 2018** and **19 December 2018**, the police completed a DASH and BRAG to gain an insight to Lily and Peter's relationship. The police frequently accessed mental health triage support, but the police have identified the triage service was not as effective as it could have been.

11.2.3 Somerset Clinical Commissioning Group (CCG)

11.2.3.1 During the review period there were 16 face to face GP consultations for Lily, eleven GP telephone consultation , 8 health care practitioner face to face consultation with 5 health related telephone consultations with the practice staff. There were six occasions when Lily did not attend appointments with the practice.

11.2.3.2 There was a positive relationship between the GP and Lily and the GP practice was positive, supportive and showed a professional insight into Lily's difficulties in

11.2.4 Somerset Partnership NHS Foundation Trust (SomFT)

11.2.4.1 Between May 2016 and up to the day before Lily's death SomFT had contact with Lily on over fifty occasions of which four were related to domestic abuse. Peter had one contact which was not related to domestic abuse and Gary had no contact. Following Lily's death, a Root Cause Analysis Investigation report was carried out revieing on the events during Lily's final admission and post discharge from the ward to the time of Lily's death which identified several learning points which are included within agency recommendations.

11.2.5 Somerset Adult Social Care (SASC)

11.2.5.1 SASC Mental Health Social Care service had indirect contact with Lily on seven occasions of which none related to domestic abuse. There was reference on records explaining why Lily did not meet the Care Act eligibility threshold for Social Care following assessment. Lily did have a long-standing involvement with the Community Mental Health Team and Lily was referred to MHSC team twice in the review period, but records reflect Lily had a social care assessment, but the recording was limited.

11.2.5.2 The IMR author noted that Lily had two admissions to the psychiatric hospital in **November 2017** and **May 2019** and the admissions may have benefitted from MHSC interventions. Although Lily was never detained under section 3 of the Mental Health Act and therefore not eligible for 117 aftercare[22] her needs were not considered under the Care Act 2014 in supporting her wellbeing.

11.2.6. Somerset Integrated Domestic Abuse Service (SIDAS)

11.2.6.1 Lily was referred to SIDAS by the LSU on 20 December 2018 and her DASH was 10. At the time of the referral, Lily , Gary and Peter were not on any database of SIDAS. The SIDAS Intake coordinator was not able to contact with Lily on the

[22] 117 Aftercare ;Free aftercare after hospital discharge, Under Mental health Act 1983- Only entitled to section 117 aftercare if you have been in hospital under sections 3,37,45a, 47 or 48 of the Mental Health Act 1983 -Rethink Mental Illness- www.rethink.org Section 117 aftercare.

telephone number given. SIDAS standard practice was to contact the victim and go through an introduction to the service, understand their wishes, hear their voice and seek consent. Two attempts were made to contact Lily and the call went to voicemail. No message was left and SIDAS policy is that it not considered safe in case a third party had access the mobile. The incident report related to Gary only and SIDAS never received a referral where Peter was a perpetrator. There had been previous police call outs with medium /standard DASH reports, but these had not been referred to SIDAS. The SIDAS hub did make the MARAC aware of Lily as they considered Lily at high risk of domestic abuse, but the case was not called or listed.

(*The reason stated for non-listing by the MARAC coordinator was due to lack of clarity as to who the perpetrator was, Peter or Gary)*

11.2.7 South West Ambulance NHS Foundation Trust (SWAST)

11.2.7.1 SWAST had twelve contacts with Lily between **May 2016** and **June 2019** and three with Peter. The only episode of domestic abuse was the contact with Lily on **23 November 2018** and SWAST followed appropriate processes and made a safeguarding referral to the police and a copy to the GP.

12. ANALYSIS

12.1 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.

12.2 Key Themes were identified through the IMRs and discussion with professionals involved with Lily, Peter and Gary

- Domestic Abuse: physical and coercive and controlling behaviour.
- Mental Health Issues relating to Lily including suicidal ideations.
- Substance abuse by Lily
- Familial abuse, Lily and Gary and lack of understanding by professionals.
- Lack of understanding of all Lily's needs.
- Lack of case management
- Lack of record keeping about Lily and her needs.
- Lack of understanding by professionals of the links between mental health, substance abuse and domestic abuse.

- A victim being in repeated domestic abusive relationships.
- A victim of domestic abuse as an alleged perpetrator.
- Lack of the family voice being heard.
- Professional bias
- Professional curiosity
- Constant "firefighting" by agencies to support Lily, inability for a holistic approach.

12.3 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. This also to include the dynamics of coercive control, understanding the links with mental health and substance misuse and knowledge of familial abuse.

12.3.1 The facts have identified that Lily, Gerry, Peter, Gary and Tom appear to have had very volatile relationships. The police identified thirteen domestic incidents in their records for the period of this review but also had records of many domestic incidents between Lily and Gerry. Lily was arrested three times for battery against Gerry, one incident resulted in a caution, and another proceeded to trial with Lily, being found not guilty. Gary was present and involved in several the arguments with Lily being arrested twice for battery against Gary in **2011** and **2015**, with the incident in **2015** proceeding to court but with drawn as Gary did not want to attend.

12.3.2 The police identified Lily as a perpetrator of domestic abuse and as a victim of abuse by Gary, Tom and Peter, her partner. An incident in late December 2018, when Peter allegedly physically abused Lily, Lily alleged that Peter was trying to control her. Peter was arrested and questioned about the incident and the controlling coercive behaviour. Peter did offer an alternative explanation, that Lily had hit him, and he was trying to defend himself and that there was an issue of trust between them. The police recorded on its Storm contact record about Lily's complaint about controlling coercive behaviour so the call handlers would have a historical record in case any further disclosures were made by Lily. On each incident that the police were involved with Lily, a referral was made to LSU and LSU attempted to contact Lily in connection with the assault.

The DHR Panel has identified that although the police did look at investigate each incident on an individual basis and did offer support for Lily there appears to have been no linking of all the incidences by the police which could an indicated an escalation of domestic abuse and an escalation in Lily's mental health. The police force

is undertaking DA Matters Training and it will be important that police officers consider the historic allegations by a victim of domestic abuse to build a complete chronology of what the victim has experienced and is happening in their lives to enable the provision of the most appropriate support.

12.3.3 The police have shown that they do have a thorough understanding of controlling, coercive behaviour and referred Lily to support services such as LSU and considered a referral to adult social care but Lily did not meet the criteria.

12.3.4 What is evident from the information provided is that health and social care professionals focused on Lily's mental health needs and her substance abuse and appeared not to consider the domestic abuse that Lily was experiencing. It is not clear whether this was due to a lack of understanding by professionals of domestic abuse in all its forms or that professional did not consider domestic abuse as an issue.

12.3.5 Lily did appear to understand controlling coercive behaviour as she disclosed to the police that she felt Peter was controlling and coercing her.

12.3.6 Women's Aid defines coercive control as an act or a pattern of acts of assault, threats, humiliation and intimidation that is used to harm, punish or frighten their victim. This controlling behaviour is designed to make a person dependent by isolating them from support, exploiting them, depriving them of independence and regulating their everyday behaviour.[23]

12.3.7 Coercive control is not primarily a crime of violence but, as Evan Stark (2007)[24] describes, it is a 'liberty crime'. Stark provides a breakdown of coercive controls, e.g. degradation and shaming. Stark goes on to liken coercive control to being taken hostage. He says "the victim becomes captive in an unreal world created by the abuser. Entrapped in a world of confusion, contradiction and fear." Section 76 of the Serious Crime Act 2015 provides for the offence of controlling or coercive behaviour in an intimate or family relationship and there are examples detailed in the fact section that Lily suffered controlling and coercive behaviour from her partner and her sons.

12.3.8 The Domestic Abuse Act 2021 has created a statutory definition of domestic abuse, emphasising that domestic abuse is not just physical violence, but can be emotional, controlling or coercive and economic abuse.

12.3.9 What is not clear fully from information is what Peter was allegedly doing to control Lily. Although Lily stated that Peter had used her money to pay for food and

[23] How can you tell whether you are a victim of coercive control- Here are the signs – Telegraph 28 Feb 2019. www.telegraph.Radhika Sanghani
[24] Stark. E Coercive control. The entrapment of women in personal life. 2007

he was asking her to shop and cook, Lily must have felt controlled as she reported it to the police and therefore must have understood what being controlled felt like. *(Example of possible economic abuse by Peter)*

12.3.10 Lily also informed the police that Tom had allegedly told her that he was going to take her up into an area and set fire to her. If Tom did say this then Lily would have been very fearful, it would have impacted on Lily's already fragile mental health and therefore this would have been defined as coercive control by Tom.

12.3 11 Lily disclosed that Gary has assaulted her in October 2018, later in November 2018, Lily phoned the police to say Gary was behaving aggressively towards her.

12.3.12 Although the IMR identifies that the Police have a good understanding of domestic abuse in all its forms the IMR author did identify that when Peter was taken into custody in December 2018, a more focussed questioning could have been directed at Lily. This could have established firm evidence of controlling coercive behaviour by Gary and Peter although it may have taken more than a one-off conversation with someone to identify controlling, coercive behaviour due to it not being one dimensional . This would then have enabled Officers to have made a more aggressive line of questioning of Peter.

12.3.13 Lily had significant contact with health, GP and specialist mental health services and to a lesser extent contact with ASC. There is no information within the IMR's that any routine enquiry was made by professionals with Lily about domestic abuse and this was a missed opportunity. Professionals need to fully understand all aspects of domestic abuse and the links between mental health, substance abuse and domestic abuse. This will be discussed later in the report.

12.4 Adult Family Violence (Familial abuse)

15.4.1 This review highlights that Lily was not only experiencing Interpersonal Partner Violence (IPV) by Gerry and Peter an also Adult Family Violence (AFV) by Tom and Gary. Research by Nicola Sharps -Jeffs and Liz Kelly 2016 shows that AFV is gendered where typically sons inflict abuse. The research also identified that the dynamics underpinning IPV and AFV are different and that more research is needed in this area of risk identification and management of risk. DASH RIC have been developed for IPV and not AFV and some of the questions on a DASH are not relevant and therefore may not help professionals to access the risk. The most frequent risk factors identified for

perpetrators of AFV to emerge are mental health, alcohol or substance misuse or previous criminality.[25]

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

Civil Interventions

12.5.1 Intervention of specialist domestic abuse services.

12.5.1.1 The police made a referral to the LSU on several occasions in **2018** and **2019**. In **late November** following a 999 call from Lily to report that Gary was being aggressive towards her, the IAU asked the LSU to review their engagement with Lily. The LSU tried to contact Lily twice but were unsuccessful.

12.5.1.2 Lily was referred by LSU to SIDAS late **December 2018** and neither Lily nor Gary was known to SIDAS. The incident referred was that Gary had assaulted Lily two months previously and that he was constantly being abusive both physically and verbally to her.

12.5.1.3 SIDAS tried to contact Lily by telephone as is their standard practice. The purpose of the initial contact is to go through an induction to the SIDAS Service, to try to understand a victim's wishes, hear their voice and seek consent. Two calls were made but were not answered. The standard safety practice is not to leave any messages as a third party could access Lily's mobile. The LSU and SIDAS referred Lily into the MARAC process for the incident above incident (although the case did not meet the automated MARAC referral threshold of 14 yes answers) and was referred because of the officer's professional judgement. Following Lily's witness statement, the OIC for the assault by Gary noted that Lily had changed her account in her witness statement and said that the assault was perpetrated by Peter and not Gary and the case was filed. A MARAC Coordinator reviewed the incident **late January**. It was determined it would not be referred to a MARAC due to the uncertainty of the suspect. There is no evidence to confirm whether Lily was updated specifically about her allegation against Gary.

12.5.1.4 The DHR Panel notes that the incident was referred for MARAC but due to the uncertainty as to who the perpetrator was, the MARAC coordinator decided not to proceed and therefore identified the following;

[25] Domestic Homicide Review Case Analysis -Report for Standing Together Against Domestic Violence. 2016. www.static.squarespace.com

That a victim of DA should be referred to MARAC even if it is unclear as to who the perpetrator may be.

12.5.1.5 The DHR Panel also commented that the MARAC coordinator did not consider the referral for three weeks and that the review of the MARAC, which is taking place in Somerset, should reflect the importance of timeliness of decision making.

12.5.2 Specialist Drug and Alcohol Services

12.5.2.1 Many of the health the agencies involved with Lily knew of her use of alcohol and overuse of prescription drugs, resulting in multi attempts at self-harm and overdose (42 overdoses since Lily was 20 years old). One overdose was so medically serious that Lily was in intensive care.

12.5.2.2 From information within the IMR's before Lily was discharged from hospital prior to her death, SOMFT professionals supported Lily to make an initial contact with SDAS to discuss what support could be available. Sadly, no further contact was made as Lily died two days later.

12.5.2.3 Although the police, SOMFT and Lily's GP identified alcohol and prescribe medication abuse the key focus was around Lily's mental health and the abuse she was experiencing, and the substance misuse was considered an issue in Lily's life, but it would appear there was no integrated approach in supporting Lily's needs. Safe lives identified that all three are indicators of increased risk of harm to families and are significant factors in Interpersonal Violence and Adult family violence. Save Lives also identified that the professionals need to understand that risk is dynamic, and fluid and that relevant and proportionate information sharing is justified, and that professional should use their professional curiosity skills to fully understand what is happening in the life of a victim so they can be fully supported.

12.5.2.4 Over the past few years and following research especially in safeguarding there is an increased awareness of the frequency with which domestic and sexual violence, substance use, and mental health problems co-exist, in Lily's case she experienced all three for many years.

12.5.2.5 If Lily could have been referred earlier by professionals to SDAS then perhaps Lily's needs could have been more appropriately supported.

12.5.2.6 SDAS is run by Turning Point and provides a range of services which may have been able to support Lily and the family including alcohol support, drug support and family support.

12.5.3 Mental health interventions.

12.5.3.1 Lily was involved with mental health services for many years including thirteen previous admissions to acute psychiatric inpatients units between 1998 and 2017 and her final admission was in May 2019 (her 14th after an 18-month gap. Lily had a care coordinator between 2012-2017 who appeared to have built up a good relationship and knew her well. There had been attempts for Lily to have psychological therapy, but this was not successful as Lily continued to use alcohol and drugs. Discussions took place with Lily in 2016 around working towards her discharge from the Community Mental Health Services in late 2016 and this was worked towards under the "orange card" system which enabled Lily to re-access services as needed. *(The Orange card system is no longer in operation. The Orange card was primarily a process that enabled discharged clients to directly self-refer into secondary mental health services, but this has now been replaced by the provision of duty team and home treatment team numbers in addition to Samaritans[26], Mindline[27] upon discharge)*. From 2017 Lily did not have a care coordinator but was supported through the Home Treatment Team (HTT).

12.5.3.2 Lily's last admission to hospital was late **May 2019** following an impulsive overdose of gabapentin and olanzapine following an argument with Peter and Tom. Lily was admitted as it was felt that she was considered at a significant risk of accidental death. Professionals felt that the safest option for Lily was to admit her to a ward for a period as she had taken two overdoses within two weeks and her engagement with HTT was limited.

12.5.3.3 Lily was admitted to the same ward on which Gerry, her husband, had died three years earlier. This caused much anxiety for Lily, although due to pressures on mental services it is not known whether a bed was available in another ward or hospital although pressure on bed places may have been a difficulty. If it is possible, professionals should try to consider family history when a patient is being admitted to a ward, but the DHR Panel understand that this may not always be possible.

12.5.3.4 Lily's behaviour changed when she was told that she was being prepared for discharge in late **May 2019**. Lily became more aggressive to staff and engaged less. There is no evidence to indicate whether professional considered the change in Lily's behaviour. Lily could have feared going home as there was evidence that she had suffered domestic abuse from Peter, Gary and Tom. Despite there being the link between mental health issues, substance misuse and domestic abuse there was never

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[26] Samaritans -www.samaritans.org
[27] Mindline in Somerset- wwwmindinsomerset.org.uk

a routine enquiry about any domestic abuse that Lily may be experiencing which may have caused behavioural change.

12.5.3.5 Mental health professionals may have considered Lily being detained under the Mental Health Act 1983[28] and following Lily's death and as part of the SOMFT Root Cause Analysis Lily's, Lily's family asked why she was not detained. SOMFT professionals explained that as a service the least restrictive option around inpatient admission must be considered as the most appropriate. Lily had been assessed as having capacity to understand and accept decisions around her care.

12.5.3.6 What is evident around Lily's discharge for the final time is that the family had concerns. Tom contacted the hospital to voice his concerns and despite this Lily was discharged. SOMFT identified that a family liaison meeting should have been offered so that their views could be considered and to inform the ongoing support and interventions for future care and treatment for Lily and her family.

12.5.3.7 Lily's sister stated that Lily missed the support of the Care Coordinator, especially as this service was removed just six months after Gerry's death.

12.5.4 Support from Adult Social Care

12.5.4.1 Considering Lily's care and support needs between 2016 -2019 there was limited contact by the ASC with Lily. There were six contacts and one case recording. Lily was provided with information about Village Agents and the Community Mental Health Team. Village agents are trusted, well trained and knowledgeable individuals who are employed by the Community Council for Somerset and help individuals to find a person's needs in the local community .[29] What is clear from information provided is that ASC never considered domestic abuse as an issue in Lily's life. Professional focused on Lily's mental health needs and did not take a holistic view of the challenges in Lily's life.

12.5.4.2 When Lily was admitted to a psychiatric hospital in November 2017 and in May 2019 (just before her death) she may have benefitted from MHSC interventions whilst on the ward to access Lily's needs for social care and support post discharge. Although Lily had never been detained under Section 3 of the mental health Act, and therefore was not eligible for 117 aftercare, Lily may have had needs under the Care Act 2014 in supporting her wellbeing. This could be considered as a missed opportunity. There may be an opportunity to review the discharge planning process to ensure there are appropriate referrals to external agencies.

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[28] www.nhs.uk mental health and the law

[29] www.somersetcommunity.org.uk-People who can help you find the information you need.

12.5.5 Suicide Prevention Services

12.5.5.1 The Department of Health developed a suicide prevention strategy in England in 2012 "Preventing suicide in England"[30]. The strategy had the overall objective of reducing the suicide rate in the general population in England and providing better support for those bereaved or affected by suicide. One of the key areas of action is to reduce the risk of suicide in key high -risk groups. Although men aged between 35-49 are three times at greater risk of suicide, Lily did have a history of self-harm and so did her family, her father's death was by suicide as was Gerry, her husband.

12.5.5.2 Data for England in 2020 states that 3882 men died by suicide and 1230 women. This was a decrease of just over 8% for men and nearly 6 % for women from 2019 data. Somerset has higher than the national average death by suicides. Between 2005-2019 there have been 779 recorded deaths by suicide, an average of fifty per year. The age standardised suicide rate for Somerset for the period 2017-2019 was 13.1 per 100,000 statistically higher than the national average for England of 10.1. Rates of mortality from suicide for both females and males were highest for those aged 35-64 and Lily fell into this age bracket. [31]

12.5.5.3 Somerset Suicide Prevention Partnership works with several local organisations such as the Samaritans[32], Somerset Mindline[33] and Taunton Rail Responders[34] to deliver Somerset's Suicide Prevention Strategy 2018-2021[35]. Some of the key areas of action are to:

I. Reduce risk of suicide in high-risk groups,
II. Tailor approaches to mental health support in specific groups
III. Reduce access to means of suicide
IV. Provide information and support to individuals bereaved by suicide
V. Support the media to report appropriately on incidents of suicide
VI. Implement research, data collection and monitoring.

12.5.5.4 The National Institute for Health Research identifies [36]that certain factors can increase the risk of suicide including drug and alcohol misuse (applicable to Lily), history of traumatic life events or abuse (Lily's father and husband both died from

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[30] www.gov.uk Suicide Prevention Strategy for England 2012
[31] Somerset Intelligence . Suicide Prevention www.somersetinteligence.org.uk
[32] www.samaritans.org
[33] www.mindinsomerst.org.uk
[34] www.tauntonteamchaplaicy.org
[35] www.somersetintelligence.org.uk- Somerset Suicide Prevention Strategy 2018-2021
[36] Nihr.ac.uk National Institute for Health Research. Suicide prevention in high-risk groups

suicide) mental health issues (Lily) and self-harm (Lily), violence (Lily). Unemployment, social isolation, poverty, and poor social conditions are also high-risk indicators.

12.5.5.5 A study by Warwick University in 2018[37] with Refuge, focusing on more than 3,500 women who were being supported by Refuge uncovered that almost a quarter of victims of domestic abuse felt suicidal at one time or another and 83% reported that they felt hopelessness and despair, a key symptom of suicidal ideation.

12.5.5.6 Professor Sylvia Walby, in her research, identified that one in eight female suicides and suicide attempts in the United Kingdom are due to domestic abuse. This equates to 200 women taking their own lives and 10,000 attempting to do so due to domestic abuse[38]. This research identifies the link between domestic abuse and suicide/suicide ideation.

12.5.5.7 There is no evidence that Lily or her family sought any specific suicide prevention service or that any sign posting was considered by other agencies. Although some of the agencies involved with Lily were aware of her attempts to self-harm, there appears to have been no consideration as to whether specific suicide prevention services could have been suggested to Lily and her family.

12.5.5.8 Evidence provided for this DHR would indicate that Lily was at risk of death by suicide and that professionals should have considered the risk as potentially high and plan Lily's safety accordingly.

12.5.6 Grief Counselling and Support for Lily

12.5.6.1 Lily told many professionals how she missed her husband Gerry and how sad she was. No agency involved in Lily's life appears to have considered Lily's grief as a reason for Lily's substance abuse or the impact on her mental health. Grief in a natural emotional response to the loss of someone close and in Lily's case it was Gerry. Everybody reacts differently to grief with some common feelings including sadness, shock, guilt and anger. Due to people's emotions a person suffering from grief may have difficulty in concentrating, they may drink, smoke or use drugs as a coping mechanism. A person's physical health can also be impacted upon, and grief can sometimes be complicated and intense. [39]

12.5.6.2 Lily's grief was not considered by professionals as to being an issue for her and that she may need support. With Lily's well documented mental health issues it

[37] Domestic Abuse and Suicide ;exploring the links with Refuge clients 2018. Ruth Aitken and Vanessa Munro.www.wrap.warwick.ac.uk/103609/
[38] Domestic Abuse and Suicide. Hestia- Life Beyond Crisis. www.hestia.org
[39] Understanding grief- Cruse Bereavement Support www.cruse.org.uk

may have been more difficult for Lily to navigate her grief, and hence she may have taken drugs and alcohol to try to alleviate her sad feelings.

12.5.6.3 Somerset has several bereavement support services such as Mind in Somerset[40] and Somerset Suicide Bereavement Support Service[41]. If professionals had considered grief as an issue for Lily, she and her family could have been signposted to organisations who may have been able to help Lily with her grief which may have had an impact on her overall wellbeing.

12.5.7 Multi Agency Referral Assessment Conference (MARAC)

12.5.7.1 A MARAC is a monthly risk assessment meeting were professionals from different agencies professionals. share information on high-risk cases of domestic violence and abuse and put in place a risk management plan. The purpose of the MARAC is to safeguard a victim. manage perpetrators behaviours, safeguard professionals and make links with other safeguarding processes. [42]

12.5.7.2 A referral was made by SIDAS to the MARAC in late December 2018 about Lily as SIDAS had not been able to contact Lily. Although the case was risk assessed as standard on professional judgement there were some high concerns and hence the submission to the MARAC. The case was never called or listed to the MARAC. On requesting confirmation as to why the case was not listed, the Police records identified that the alleged assault by Gary on Lily (28 October 2018 and reported on 19 December) was reviewed by a MARAC coordinator on 17 January 2019 but determined it would not be referred to MARAC due to the uncertainty in the identity of the suspect and what happened. It was believed that Lily had changed the identity of the perpetrator from Gary to Peter during the investigation.

The DHR Panel noted that the referral was not reviewed for a month, and this is too long. It is well documented that domestic abuse can escalate very quickly and therefore it is imperative that agencies respond to risk in a timely manner.

The DHR Panel have noted the review of the MARAC by SSP and would recommend that a time frame is included for a referral to MARAC which is based on best practice.

12.5.7.3 Lily was involved with several agencies, and she had complex needs, mental health issues, substance abuse and suffering domestic abuse. A MARAC would have provided an opportunity to review what was happening in Lily's life and to coordinate a holistic response to her needs. Information about Lily and her family would have

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[40] www.mindinsomerset.org.uk
[41] www.somersetmentalhealthhub.org.uk
[42] www.safelives.org.uk Principles of an effective MARAC

been shared, action planning for Lily would have taken place, which could have addressed her needs, her risks and reviewed the support she needed.

Legal Interventions

12.5.8 Domestic Violence Protection Notice (DVPN) /Domestic Abuse Protection Notices (DAPN)

12.5.8.1 The Domestic Abuse Act 2021 has delivered the Domestic Abuse Protection Order which for the purpose of preventing a person from being abusive towards a person aged sixteen or over to whom they are personally connected.

12.5.8.2 It would prohibit the perpetrator from doing things described in the order or require the perpetrator to do things in the order;

12.5.8.3 A domestic abuse protection order may be made on application or during certain proceedings which;

- Prioritises the safety of survivors,
- Result in a criminal sanction if breached by the perpetrator,
- Places responsibility on the perpetrator to stop abuse. [43]

12.5.8.4 The DAPN 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.

12.5.8.5 A DAPN 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.

12.5.8.6 The police considered issuing a DVPN twice but were determined not to be appropriate, in October 2018 when Gary allegedly punched Lily in the face, resulting in a visit to accident and emergency and in late 2018 when Peter was taken into custody for allegedly attacking Lily.

12.5.8.7 A DAPN will be an effective tool to support victims such as Lily, but the Centre for Women's Justice (CWJ) argues that although Domestic Violence Protection Notices (DVPNs) and Orders were introduced in (2014) as an additional protection for women

[43] www.gov.uk Domestic Abuse Act 2021

were "rarely used"[44] it is hoped that a DAPN is used to protect victims. *(Domestic Abuse Act 2021, Part 3 section 22)*

12.6 To determine if there were any barriers for Lily or her family / friends faced in both reporting domestic abuse and accessing services. (This to be explored against the Equality Act 2010's protected characteristics).

12.6.1 Lily had many contacts with agencies over a number of years, mainly health (GP and Mental health Services), the police and to a lesser extent ASC. The police recorded 13 domestic abuse incidents with Lily as a victim and a perpetrator. The Police did consider Lily at risk on several occasions and made a referral to the LSU, although they struggled to contact Lily.

12.6.2 Lily may have struggled to navigate and engage with the services and professionals need to understand that a victim of domestic abuse may struggle to engage. Professionals often state in records, the victim "did not engage" without questioning why the victim did not engage.

12.6.3 Also as Lily was allegedly abused by her partner and her sons and therefore Lily would not be able to seek any family support. Lily may have benefited from forming a trusting relationship with someone external to the family.

12.6.4 Lily 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 evidence to suggest that Lily experienced domestic abuse in her marriage to Gerry both as a victim and a perpetrator and this continued within her relationship with Peter, Gary and to a lesser extent with Tom.

12.6.5 Although Lily was not registered with a disability, her mental health and her substance abuse would have added to her vulnerabilities and could have impacted on further on her health and wellbeing. Safelives report Safe and Well ; Mental Health and Domestic Abuse[45] found a strong association between having mental health problems and being a victim of domestic abuse. It also identified that domestic abuse often goes undetected within mental health services and that domestic abuse services are not always equipped to support mental health problems. This can cause a barrier to the support a victim may need.

12.6.5 Peter was black but little further information is known about his ethnicity. Once domestic abuse incident related to Lily allegedly calling Peter a "gorilla" which he did

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

[45] Safe and Well;Mental Health and Domestic abuse, Safelives www.safelives.org.uk

not like and he allegedly "poked" Lily's face. Peter's ethnicity and Lily allegedly calling him a name which is conceived as being racist appears to have a triggered some physical abuse.

12.7 To discover whether agencies complete safety plans for people who are self-harming /suicide risk and to what extent people are encouraged and/or supported to complete self-held safety plans.

12.7.1 The police identified Lily as a vulnerable adult and made effective use of identifying risk via an officer perceived DASH when Lily was unable to complete a victim led DASH, with referrals to the LSU to enable Lily to get the support she needed. There is evidence that the police increased the DASH level to emphasise the risks relating to Lily around her mental health, her substance misuse and the number of attempts by Lily to commit suicide.

12.7.2 The Police IMR author had identified that a case management approach would have been beneficial for Lily. The majority of the domestic abuse incidents were clustered in the six months from July to December 2018. Each incident was investigated as a discrete and unconnected case, and it is not clear that these incidents were reviewed together to establish if there was a wider domestic abuse context within Lily's home. (To note a MARAC would have proved the multi- agency review) The IMR author noted that certain incidents were determined to be mental health episodes in which no offence happened. If a case management approach had been utilised this should have allowed for improved professional curiosity.

12.7.3 Whilst Lily was in hospital, before her death, Lily's suicide risk was assessed as low in the short team however recorded as a significant risk in the longer term. There is evidence that there was no recorded evidence that Lily's suicide or risk of accidental death was actively explored at the point of discharge in line with SOMNHS Clinical Assessment and management of risk policy. It is recorded that professionals who were present at Lily's final review meeting before her discharge, stated that Lily was well and was willing to engage with her treatment plan.

12.7.4 What is evident is that Lily's family were not included in her safety planning on her discharge. SOMFT have acted upon a recommendation in the RCA relating to this. There is some concern by the Panel that evidence identifies that family members were allegedly abusing Lily then involving the family could have put Lily more at risk. If it is not appropriate to involve a family in discharge planning then a more appropriate family member should be considered, for example, Lily's sister.

12.8 To consider professionals perceptions around victim/perpetrator behaviour which may have impacted on support for the victim (confirmation bias)

12.8.1 Lily was well known to the police and to mental health services and it would appear from records that Lily had a history of violence and to make false allegation especially when intoxicated including anti- social behaviour incident in November 2017. Some comments detailed within the IMR would indicate that some professionals were victim blaming, e.g. did not engage, reliability of information. There is some evidence to suggest that professionals may have shown some confirmation bias particularly as Lily was well known to certain agencies.

12.8.2 Everyone has their own confirmation bias, even for people who are open minded, it is still likely that some bias will help shape the opinion. Professionals can also exhibit confirmation bias when they look for evidence that supports or confirms their pre-held view and ignores contrary information that challenges it. It occurs when professionals filter out potentially useful facts and opinions that do not coincide with their preconceived ideas.[46] Health professionals cite that Lily had a history of missed or cancelled appointments, that she repeatedly avoided engaging with mental health and drug services and this would appear to build up a picture that Lily was not trying to help herself or the children. Language used by the professionals included "Lily failed to engage" which would indicate it was Lily's choice as opposed to "Lily was unable to engage."

12.8.3 Dr Carlene Firmin states that professionals should consider the language used when describing a person's situation whether it be a child or adult (contextual safeguarding).[47]

12.9 Did professionals use their "professional curiosity skills" to understand the needs and know the victim better.

12.9.1 The review identifies that there were complex issues in Lily's life starting in her twenties when her mental health deteriorated, Lily was suffering substance misuse and a relationship with Gerry , her husband, which from evidence provided, was very volatile and abusive with Lily being a victim and a perpetrator. It has already been documented that Lily had complex needs but professional appeared not to have tried to understand why Lily drank and took drugs, was it a coping mechanism for abuse she was suffering, her grief or related to her mental health.

[46] Somerset Adult Safeguarding Board https://www.somersetsafeguardingadultsboard.info/assets/
[47] Contextual safeguarding: https://csnetwork.org.uk/about/what-is-contextual-safeguarding

12.9.2 Analysis of the IMRs highlights that if agencies had researched historical incidents, linked incidents together using case management, then a pattern of domestic abuse, mental health and substance abuse could have been established which would have given agencies a better understanding of Lily's needs.

12.9.3 For example, the police concentrated on the issue of domestic abuse and Lily's mental health, SOMFT and GPs focused on Lily's mental health and no agency appears to have taken time to understand "why does Lily turn to drug and alcohol use." Domestic abuse and Safeguarding training need to equip professionals with the tools to be curious and build up a complete picture of an individual so the most suitable support can be provided.

12.9.4 Somerset Safeguarding Adult Board has produced a guidance document about Professional Curiosity; what it is, the barriers and how a professional can be professionally curious.[48] This guidance should be promoted to all professional in order to ensure professional curiosity is embedded into professional practice, including organisations with less experience of dealing with a complex number of issues.

13.CONCLUSION

13.1 Lily's death was unexpected by professionals, but the risks of her death were documented with numerous attempts at self- harm. Lily was a very vulnerable person. Her childhood experiences may have impacted on her ability to make decisions, to assess risks and to manage her safety in adult life. Lily suffered from mental health issues from her late teens. Lily was married for over 25 years and although the relationship was volatile with Lily as a victim and a perpetrator of domestic abuse, but when Gerry, her husband took his life in 2016, she suffered a lot of grief and sadness. Lily also suffered with her physical health with chronic back pain, suffered from alcohol and drug misuse (why she did was never identified) and Lily was allegedly a victim of domestic abuse, both IPV and AFV.

13.2 This review identifies that Lily was involved with several agencies, with each trying to help Lily with one aspect of her needs, e.g. mental health, physical health with only the Police considering domestic abuse and her mental health. There was no consideration about the impact of grief on Lily's life and any exploration of why Lily drank and took drugs by professionals. No agency saw the bigger picture or background to what Lily had experienced and was experiencing.

[48] Somerset Safeguarding Adults Board

13.3 Lily's case, although referred to a MARAC was never listed and therefore never discussed. Lily had multiple issues and a MARAC or a multi- agency meeting (using the "What to do if it's not Safeguarding" process) would have provided an opportunity for professionals to have all the information about Lily, which would have described a very vulnerable person who needed support and guidance to navigate services which could have helped her. e.g. drug and alcohol services. A multi-agency approach may also have helped the family navigate support for Lily's needs.

13.4 There are examples of agencies being supportive of Lily, especially the police who considered several safeguarding measures for Lily but often each contact was managed in isolation from another. A case management approach by the police may have helped Lily with a more integrated approach to what she was experiencing.

13.5 Lily, due to her complex needs would have benefitted from a multi-agency approach in trying to address the support that she needed. Agencies need to use the MARAC and if not appropriate another multi agency model to support a victim of domestic abuse who has complex needs to be able to navigate what support is available and how to access it. Lily was always seen as having mental capacity and was included in decision making (a strength in Lily) but also one IMR author noted that her impression of Lily was that she was lonely, she missed her husband and often worried of how she was perceived by others.

13.6 In the absence of any family or friend input into the voice of the victim, the DHR Panel would wish to say that Lily did engage with professionals, she understood what domestic abuse was, she attended appointments and did appear to miss her husband who she lived with for over 30 years. Lily, despite her vulnerabilities did show strength when trying to deal with her complex issues. It was also noted that no one ever asked what Lily's aspirations for the future were. This may have helped professionals to understand Lily in a holistic way.

14. LESSONS LEARNT

14.1 Multi-Agency response for victims of DA with complex needs.

14.1.1 Lily was involved with several agencies over many years, especially health services including mental health (from her mid 20's) and primary care. The police had over fifty contacts with Lily and her family of which fifteen related to domestic abuse. Lily suffered with alcohol and drug misuse over many years, but Lily did not engage with any specialist support (only one phone call prior to discharge from hospital June 2019). Although Lily did have contact with ASC, and Lily was referred by the Police in

2017 Lily did not meet the threshold for a safeguarding enquiry under Section 42 of the Care Act.

14.1.2 Lily was a vulnerable adult with many needs, suffering from mental issues over many years including hospitalisation and several attempts at self-harm including attempts to take her own life. Lily was identified as a victim and perpetrator of domestic abuse, suffering abuse from not only her partner but also her sons. Lily suffered with chronic back ache and from alcohol, prescription and illegal drug abuse. Lily was involved with several agencies, but evidence indicates that each agency was trying to resolve /support one aspect of Lily's life, mental health, physical health, domestic abuse/antisocial behaviour with no holistic approach.

14.1.3 The Police IMR indicates some good practice in attempting to support Lily's needs including referrals to LSU, consideration of referring to ASC but often each incident was considered in isolation and therefore although Lily was well known to the local Police a full history of her issues and needs was never known or considered.

14.1.4 In carrying out this DHR, Panel members have been able to provide a wealth of information about Lily including her childhood experiences which may have impacted on her life and her ability to make choices which could have protected her. Not all the agencies involved with Lily were aware of the domestic abuse she was experiencing. As one professional stated, "often, trying to support Lily was about firefighting."

14.1.5 It has already been documented that Lily was referred to a MARAC **in 2018** but the case was never heard. The reason stated for not listing Lily to the MARAC was the inability by agencies to confirm who the perpetrator was. If the case had been heard it would have provided an opportunity for a multi-agency approach to try to support Lily in a coordinated manner. Professionals would have been able to provide information about Lily's early life, the support that was been given by agencies and professionals would have had a better understanding of what was going on in Lily's life and therefore more intelligence to review what support would be most appropriate for Lily and how best she could be safeguarded.

As already detailed in 12.4.1.4, , even if it is unclear who the perpetrator is , a referral should be made to MARAC.

15.1.6 Another multi agency approach which could have been considered in order to help Lily is the guidance offered by Somerset Safeguarding Adults Board, "What to do if it's not Safeguarding".[49] The guidance is how professionals respond to people with

[49] ssab.safeguardingsomerst.org.uk- What to do if it is not Safeguarding.

complex needs or circumstances who do not require and adult safeguarding enquiry under section 42 the Care Act (2014) or where it has been determined that a non-statutory enquiry is not required.

14.1.7 The guidance states quite clearly that a multi-disciplinary approach may be required when adults with complex mental health issues, long term physical health needs and people with chronic self-neglecting behaviour. The guidance does state that if a decision needs to be made sits more appropriately with another organisation , the case must be referred to that organisation, for example, if the decision is about care and support it should be referred to Adult Social Care. A multi-agency approach should be considered when;

a) An adult with care and support needs has been identified as being at risk of harm, is well known to one or more organisations with repeated concerns or presentation but there is no established plan, and they have the mental capacity. (This describes Lily)

b) Also, that there is concern about the individual's ability to manage their;

- Safety (Lily)
- Protection from abuse and neglect (Lily)
- Personal Care and hygiene
- Home environment
- Activities of daily living
- Health conditions (Lily)
- Finances

c) And that one or more organisations have concerns about an individual, (Lily, mental health service, the Police and the GP.)

d) A lead professional is identified to contact concerned practitioners to establish the multi-agency meeting, actions are documented and agreed, and a review is agreed.

e) The guidance states that if there is a substantial risk of domestic abuse then the MARAC process should be followed.

14.1.8 The DHR has identified that Lily was referred to a MARAC but was never listed and the justification, after several requests by the DHR Panel was identified as being a perpetrator could not be identified as Lily kept changing her story and her credibility was questioned. The MARAC process does need to include a recording mechanism as to why a case is not listed but more importantly to ensure a decision to not list is

driven by unconscious bias. Agencies identified Lily as vulnerable, there was an escalation of domestic abuse incidents in a brief time frame and there is no doubt Lily would have benefitted from a multi-agency approach to ensure her own safety planning and support around bot just her mental health but also her substance misuse and her grief.

14.1.9 The Police IMR author identified that Lily would have benefitted from a police case management approach, and this should be considered as part of supporting a multi-agency approach to supporting an adult with complex needs.

14.1.10 Somerset has the MARAC process and good guidance on providing a multi-agency approach when safeguarding thresholds are not met and it would be beneficial to review how the MARAC and the "What to do if it's not Safeguarding" guidance operate at present and how it could operate in the future to provide a holistic approach to supporting a victim of domestic abuse who has complex needs.

14.2 Management of Risk and Safety planning for victims of Domestic Abuse who have complex needs.

14.2.1 Lily's complex needs have already been well documented within this report, mental health, domestic abuse, drug and alcohol misuse and several recorded attempts to self-harm (including attempted suicide). As there was no coordinated response to Lily through a MARAC there was no coordinated risk assessment / planning of Lily's safety needs.

14.2.2 The review has highlighted that agency did carry out risk/safety planning with Lily. When Peter allegedly abused Lily in December 2018, the police told Peter not to stay in the house for the situation to "calm down". The police did on numerous occasions carry out a perceived DASH as Lily did not wish to proceed with a victim DASH.

14.2.3 When Lily was being discharged from mental health hospital inpatient ward in June 2019, mental health practitioners involved Lily in her discharge plan. This did include contacting SDAS, discussion around Lily's motivation and the need to try to work with SDAS as her addictions had an impact on her mental health. At Lily's final discharge meeting it was recorded that she was appropriate although had some anxiety about going home. There is no evidence that this anxiety was explored, and safety plans reviewed around the anxiety, could the anxiety be related to domestic abuse. Following Lily's death, SomFT identified that although there was concern about Lily and a risk of accidental death, there was no care plan around mitigating risk or self-harm or accidental death.

14.2.4 Local Government Association and Directors of adult Social Care (ADASS) Adult Safeguarding and domestic Abuse – "A guide to support practitioners and managers (2015)" [50]highlights the need for an assessment of risk in all situations where an adult with care and support needs is experiencing domestic abuse. Although Lily never met the criteria to be assessed under section of the Care Act 2014, Lily did have some support and care needs.

14.2.5 The guide emphasized that the assessment should be personalised and involve the person as they can identify the risks they may face. Using risk assessment tools associated with safeguarding adults, mental health and domestic abuse can assess the risk of harm to a victim. A MARAC or a multi- agency safeguarding meeting will provide a mechanism for a coordinated risk assessment and the ability to develop a safety plan for a victim with complex needs.

14.3 Mental Capacity and Lily.

14.3.1 Some victims of domestic abuse may lack capacity to take certain decisions for themselves. They may need additional help to support and empower them within a legal framework which is the Mental Capacity Act 2005. A lack of mental capacity could be due to;

- A stroke or brain injury
- A mental health problem
- Dementia
- A learning disability
- Confusion, drowsiness or unconsciousness because of an illness
- Substance misuse.

14.3.2 Despite Lily having known mental health problems, substance misuse, allegedly suffering both IVA and AVA, Lily was always considered to have the mental capacity to make her own choices and decisions. When Lily was being discharged from hospital in June 2019, mental health professionals had extensive discussions with Lily about going home, contact with SDAS was facilitated for Lily to refer herself to the service following her discharge. Information provided within the SomFT IMR highlights that Lily was well presented and engaged at the meeting to discuss her discharge and therefore there was no question about her mental capacity although it is not clear whether mental health professionals had knowledge around the abuse she was allegedly experiencing at home with Peter and Gary.

[50] Adult Safeguarding- and Domestic abuse-A Guide to support practitioners 2015 LGA and Directors of Adult Social Care www.local.gov.uk

14.3.3 Following Lily's death and as part of the RCS review, Lily's sister was interviewed. Lily's sister said that Lily benefited from having a care coordinated up to 2016. For Lily, the Care Coordinator may have provided support, some guidance and advocacy.

14.3.4 The DHR Panel understand how agencies need to change due to increasing demands and finite resources and as such Lily was referred to HTT. Lily may though, have benefitted from an advocate who could have supported her independently from family members. Faith groups and the voluntary sector do provide such services and it is important that agencies and professionals have some knowledge about what support is available within the community which could provide a vulnerable adult victim, suffering from domestic abuse but still has mental capacity, some support.

14.4 An understanding by professionals of the Impact of Adverse Childhood Experiences. (ACE's).

14.4.1 Information shared at the DHR Panel meetings indicate that Lily may have experienced ACEs. Lily's mother was a schizophrenic and her father's death from suicide (we cannot confirm this fact although it is detailed in SOMFT IMR).

14.4.2 Young Minds 2018 states that ACEs are highly stressful, traumatic events or situations that occur during childhood and or adolescence. They can be a single event or prolonged threats which can breach a young person's safety, security , trust and bodily integrity.[51]

14.4.3 There are many examples of ACEs including all forms of abuse, living with someone who is abusing alcohol/drugs, exposure to domestic abuse, living with someone with serios mental health issues and losing a parent through divorce, death or abandonment. Information identifies that Lily was living with someone who had a severe mental health issue and allegedly lost a parent to suicide.

14.4.4 ACE's can have an impact on future physical and mental health including;

- An increased risk of certain problems in adulthood, physical and mental health risks including becoming a victim of violence. (Lily)
- An increased risk of mental health issues such as anxiety, depression. (Lily)

Some of the other impacts are;

- Ability to recognise and manage emotions, emotional safety without causing harm to self or others. (Lily)

[51] Adverse Childhood Experiences(ACEs) www.youngminds.org.uk

- The ability to make and keep healthy friendships[52].

14.4.5 Professionals need to understand the impact of ACEs on a victim, how it can make someone like Lily very vulnerable. If professionals take time to understand a victims life story, then they are more likely to develop a robust risk assessment and safety plan and be better able to support that person.

14.5 Understanding of Intimate Partner Violence (IPV) and Adult Family Violence (AFV) by professionals and the wider community.

14.5.1 Lily was a victim of IPV (Peter) and AFV (Gary and Tom) including psychological, emotional, and physical abuse.

14.5.2 The UK government currently defines domestic abuse as "any incident or pattern of incidents of controlling, coercive behaviour, violence or abuse between those aged sixteen 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 abuse, psychological, physical, sexual, financial, emotional. (Home Office 2013.)

14.5.3 AVF falls within this definition and the remit of its associated legislative instruments. As already highlighted in the report (paragraph) existing practice and guidance is geared to intimate partner violence and is not always suitable for AFV such as the DASH.

14.4.4 There has been little research about AFV but the Office for National Statistics 2018[53] state at least quarter of domestic homicides involved a family member.

Research has also stated that there are certain risk factors have emerged from AFV;

1. Gender- Mothers and sisters continue to be the victims of violence from their sons and brothers (Lily abused by Gary)
2. Mental Health issues- Common feature of majority of perpetrators of AFV
3. Caring relationships and responsibilities- Including vulnerable parents being care for by children (Lily was cared for by Gary and Tom).

14.5.5 Standing Together provide a briefing sheet about AFV[54] which would help professionals and the wider community to better understand the dynamics of AFV and for professionals to consider the risk factors and support that may be required for the victim.

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[52] Manchester University NHS Foundation Thrust- Adverse Childhood Experiences. www.mft.nhs.uk
[53] www.ons.gov.uk Domestic Abuse ;findings from the Crime Survey for England
[54] www.standingtogether.org.uk Adult Family Violence Briefing Sheet

14.6 Discharge Planning from Hospital for a known Victim of Domestic Abuse.

14.6.1 Lily died the day after she was discharged from hospital. The RCA carried out by SOMFT and the actions within the review have been implemented).

14.6.2 One of the recommendations by the RCA following Lily's death is that family members are offered a family liaison meeting especially when there is a difference of opinion around treatment and timeliness of discharge.

Although the DHR Panel welcomes the recommendation above there is a concern that if it is known that the partner/children were abusing the person being discharged there should be an independent advocate (DA expert) involved whenever there is an allegation of intimate partner or familial abuse.

14.6.3 SOMFT and other agencies who may be involved with the discharge from hospital process should make enquiries with the patient about domestic abuse and plan the family liaison meeting appropriately either with a representative of the family who is not abusing the victim or an advocate for the victim.

14.7 Routine Enquiry about domestic abuse by health and social care professionals.

14.7.1 The IMR's indicated that there were no routine enquiries with Lily about domestic abuse by health professionals or adult social workers. It is well documented that GPs are the one professional that victims of domestic abuse have contact with. (Sharp-jeffs and Kelly 2016 –Domestic Homicide Reviews Standing Together)

14.7.2 Lily had significant contact with mental health services and again it is not clear whether there was any routine enquiry about domestic abuse with Lily. During the period of this review ASC professionals did not consider whether domestic abuse a factor in Lily's life. If domestic abuse is not considered a factor by a professional, then they may feel uncomfortable to raise it.

14.7.3 Health and social care professionals should be provided with training and support to enable them to make a routine enquiry about domestic abuse with a patient. Agencies should have robust policies and procedure which incorporate the need for professional to make a routine enquiry about domestic abuse. If health professionals had asked Lily a more complete picture of what Lily was experiencing would have been known and appropriate support could have been provided.

14.8 The understanding by professionals of unconscious bias when supporting a vulnerable victim of domestic abuse with complex needs.

14.8.1 Lily did have complex needs and had suffered many traumas in her life, loss of parent and a husband by suicide, grief, mental health issues including numerous attempts at death by suicide, substance abuse and domestic abuse. Lily herself admitted, especially to the police that sometimes her "story" was not as it should have been and was sometimes changed and as such Lily's credibility was undermined with professionals. Although agencies, and especially the police supported Lily and often escalated concerns and risks, for example increasing a DASH to high based on professional judgement, there is a likelihood that professionals could have had unconscious bias when dealing with Lily.

14.8.2 Unconscious bias is triggered by the brain making quick judgements and assessments. It is also influenced by professionals own personal experiences and societal stereotypes. Unconscious bias can have a major influence on attitudes and behaviours and how professional deal with a victim.[55]

14.8.3 Professionals need to understand the unconscious bias that is in everyone and that when making decisions, time needs to be taken and decisions need to be justified and base on the evidence available.

14.8.4 Evidence suggests that professionals did not think Lily was always credible in the information she provided but what is not clear is did this impact on agencies and their decision making. Did professionals see Lily's substance abuse of her "own making" as opposed to understanding why she took drugs and alcohol, was it to mask her back pain, was it to help her grief or was it to "block out" the domestic abuse she was experiencing.

14.8.5 If professionals understand unconscious bias, they are in the position to challenge their assumption about a victim, understand the victim's story and potentially provide the support they need based on evidence and sound decision making.

15. RECOMMENDATIONS

15.1 Multi Agency Response

Recommendation One

To carry out a review of the MARAC, its procedures, referrals by agencies and identification of support /safety planning offered to victims of domestic abuse.

[55] Unconscious Bias www.imperial.ac.uk

Ownership: Safer Somerset Partnership

Communication

Recommendation Two

As part of SSP communication strategy to the wider community to communications which include information about adult family violence (AFV), what it is (how to identify it) and to identify what support there is for a victim of AFV.

Ownership; Safer Somerset Partnership

Training

Recommendation Three

The Police, SomFT and CCG to identify /promote to relevant professionals and practitioners training and guidance on adopting a trauma informed approach to supporting a victim of domestic abuse. This to include identification of trauma relating to family background, grief, mental health and substance abuse. This training should also include unconditional bias, knowing how it manifests and what professionals can do to challenge it and how this impact on support to a victim of domestic abuse**.**

Ownership; Police, SomFT, CCG

Recommendation Four

SSP to review its training to professionals and practitioners to include all definitions of domestic abuse relating to interpersonal violence but also adult family violence.

Ownership; Safer Somerset Partnership

Recommendation Five

Health practitioners, police and adult social care to understand the suicide risk and links to domestic abuse and the impact of grief when a family member has experienced a death by suicide. Professionals within the mentioned organisations to also understand what support is available to families with this experience.

Ownership; CCG, Police, SomFT and Adult Social Care

Other Local

Recommendation Six

Somerset Safeguarding Adult Board (SSAB) to review "What to do if it's not Safeguarding" guidance and how it interacts with a MARAC. Also, SSAB to promote to agencies and practitioners in Somerset the model to support a vulnerable individual who may not meet the threshold of an adult safeguarding referral or a MARAC.

Ownership; Somerset Safeguarding Adult Board

Recommendation Seven

All agencies to be reminded via the SSP newsletter the importance of recording ethnicity of victims and perpetrators of domestic abuse on records e.g. Patient records/user records and crime records.

Ownership; Safer Somerset Partnership

Recommendation Eight

All agencies involved in this review, implement agency recommendations and report the outcomes to the Safer Somerset Partnership within six months of publication of this DHR.

Ownership: Safer Somerset Partnership and agencies involved in this review.

15.2 Individual Agency Recommendations/Actions

15.2.1 Avon and Somerset Police (ASP)

The following recommendations are already in progress by ASP ;
a)The Police to review its Procedural Guidance for Deployment and Crime Allocation to support case management approach for vulnerable individuals.

b)The police to take steps to ensure officers recognise coercive control more readily and take time to pursue further lines of enquiry when indicators of coercive control more readily and take time to pursue further lines of enquiry when indicators of coercive control are evident when dealing with domestic incidents.

Further recommendations.

I. The police identified that each incident was investigated as a discrete and unconnected case. If a case management approach had been implemented, then this should have allowed for improved professional curiosity.

II. The police have also recognised that further training and support for officers in recognising and investigating coercive behaviour as a learning point for the police and this is already a recommendation to improve practice.

The DHR Panel would also identify the need for the police to review its referral to MARAC procedures to ensure someone with multiple needs and suffering domestic abuse is considered by a multi-agency panel to ensure they receive the support they need.

The DHR Panel would also recommend that IAU staff are reminded of the process to make referrals to LSU.

15.2.2 Somerset Clinical Commissioning Group

I. If a person shares with a GP practice that they have been taken advantage of with the suggestion that the sexual activity was not consensual then the GP should refer to SARSAS and SARC.
II. Details of SARSAS including Welcome SARSAS Survivor Pathways (including a list of sexual violence services) should be included in the new CCG Safeguarding Service directory being developed by SCCG for GP Practices.
III. SARSAS and SARC to be invited to a GP learning event.
IV. If a person has contact with a GP service about their mental wellbeing and /or alcohol substance misuse /or chronic pain and there is no clear medical cause a GP practice should include a routine enquiry about domestic abuse.
V. *The DHR Panel question whether the GP considered the chronic pain could have been related to domestic abuse injuries.*
VI. This recommendation has been identified in previous DHR's and the action is already in process to employ a Domestic Abuse Advocate to provide GP practices with training, advice and support about having such conversations with a patient.
VII. A further action is underway by SSP in developing a health module as part of the domestic abuse training. *Since the commencement of this DHR, this module has been developed and implemented.*

The DHR Panel would also request that the CCG remind GPs of the importance of routine DA enquiry when seeing a patient.

15.2.3 Somerset NHS Foundation Trust (SOMFT)

i. Mental health services should always explore domestic abuse when relationship difficulties are mentioned and or in cases where there is a coexistence of relationship difficulties and suicide ideation.

The DHR Panel would want this lesson identified to be enhanced by the inclusion of a DASH to be completed when a patient mentions relationship difficulties so risk can be identified.

ii. Psychiatric Inpatients Units should always complete a DASH with clients who have been admitted to a ward when domestic abuse has been reported including reports of historical abuse to ensure robust risk /safety planning.

iii. To liaise with SOMFT Safeguarding Service when domestic abuse has been identifies through the completion of a DASH.

iv. Domestic Abuse Awareness raising with the Mental Health Teams to embed routine enquiry in domestic abuse in clients who present suicidal ideation or relationship difficulties.

v. To act upon the recommendations within the RCA relating to mental health and impatient processes of which all have been actioned and completed.

The DHR Panel would recommend that SOMFT review their discharge policy for victims of domestic abuse, especially if the discharge is potentially to a setting where domestic abuse has happened.

15.2.4 Adult Social Care (ASC)

I. MHSC to ensure that case recording on individual case records is accurate. MHSC teams to have monthly audit focussing on accuracy.

II. MHSC to communicate the assessment outcomes to the person involved.

III. MHSC to ensure relevant documents relating to the person are saved to their records.

IV. MHSC professionals to ensure risk assessments are completed in full and guidance is given to staff when this has not been possible.

V. MHSC to review assessment templates to ensure.

- -they are fit for purpose
- -Still relevant
- -Staff know when to apply them
- -Review effectiveness of the tools
- -MHSC to ensure that all relevant and appropriate timescales for onwards referrals are made.

VI. -MHSC and SOMFT to review their working together arrangements specifically information sharing arrangements. (To note- at the time of the incident , MHSC staff would have had access to SOMFT's electronic record system and would have recorded on the same system. Each agency would have seen each other's notes.

VII. SCC to review MHSC attendance at DA training.

VIII. SCC to ensure MHSC staff know how to recognise , respond ,report and record concerns about domestic abuse.

15.4.5 Somerset Integrated Domestic Abuse Service (SIDAS)

I. To understand the MARAC referral pathway so high-risk DA cases (whether actual score or professional judgment) should always go to a MARAC and even where there is more than one perpetrator.

Appendix One

Terms of Reference Domestic Homicide Review

DHR 033

Version 3

1. Introduction

1.1 The chair of the Safer Somerset Partnership has commissioned this DHR learning review in response to the death of Lily. The death is believed to be suicide and is within the statutory parameters for a DHR because the deceased was understood to have experienced domestic abuse within her relationship with her intimate partner and her son.

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 on of Lily in the summer of 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've experienced.

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

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children (or other dependents), 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 01.05.2016 to summer 2019 (this is intended to cover the period from a police force recorded incident between Lily and her son up until her death) 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 any proceedings in terms of timing and contact with the family.
- Aim to produce a report within 6 months of the DHR (Covid pandemic permitting) 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 following are fully explored:
    - the dynamics of coercive control
    - the understanding of domestic abuse and links with mental health and substance misuse

    - knowledge and awareness of familial abuse (rather than between intimate partners)
- To discover if all relevant civil or criminal interventions were considered and/or used.
- Determine if there were any barriers Lily 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.
- To discover whether agencies complete safety plans for people who are self-harming/suicide risk and to what extent people are encouraged and /or supported to complete self-held safety plans.
- To consider professionals perceptions around a victim/perpetrator behaviour which may have impacted on support for the victim (Confirmation bias).
- Did professionals use their "professional curiosity "skills to understand the needs and know the victim better?

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

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

5 Domestic Homicide Review Panel

5.1 Membership of the panel will comprise:

Agency	**Representative**
Independent Chair	
Avon and Somerset Police	
Adult Social Care	
Clinical Commissioning Group	
Safer Somerset Partnership	

(SCC Public Health)	
Somerset Drug and Alcohol Service	
Somerset Integrated Domestic Abuse Service	
Somerset NHS Foundation Trust	

This is subject to discussion at the first Review Panel meeting

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

7 Liaison with Media

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.

Appendix Two

Domestic Abuse Matters Change Programme for Police

Domestic Abuse (DA) Matters Change Programme overall aim:

The overarching aim of the DA Matters Change programme is to provide a programme of events which builds on and enhances the policing response to those experiencing domestic abuse and those responsible for domestic abuse. Its aim is to assist Police to act before someone harms or is harmed, identify and stop harmful behaviour, increase safety for those at risk and support people to live the lives they want after harm occurs.

The DA Matters Change Programme elements:

The programme is made up of seven elements:

- Critical Friend Health Check
- Train the Trainer Event
- First Responder Training
- Champions Training
- Sustain the Change workshop.
- Evaluation
- Ongoing support

The SafeLives DA Matters Critical Friend Health Check

Aim: To work alongside a police force to prepare for delivery of the DA Matters Change programme and for the resultant practice and attitudinal change to be sustained.

Outcomes:

- Following a 4-day review of practice and attitudes, provision of an evidence-based document summarising the outcomes from which will enable discussion and action planning within a strategic forum covering the following:
- Areas of development identified within the force to ensure that the training elements of the DA Matters Change programme have the best chance of meeting their objectives.
- Findings and suggested actions in relation to the three specific deep dive areas of review chosen by the force.
- Findings and suggested actions in relation to any additional areas of concern identified during the Health Check

The SafeLives DA Matters Train the Trainer event

Aim: To provide the learners with suitable skills and knowledge to be competent in delivery of the training elements of the DA Matters Change programme for Police

Objectives:

- Describe the origins of the DA Matters Change programme for Police
- Describe all the elements of the DA Matters Change programme for police
- Deliver the first responders training in the DA Matters Change programme for Police as detailed in the SafeLives trainer guide
- Deliver the Champions training in the DA Matters Change programme for Police as detailed in the SafeLives trainer guide
- Respond to a learner who becomes distressed during DA Matters training events according to the Responding Well Safe Operating Protocol
- Respond to a learner who is disruptive during DA Matters training events according to the Responding Well Safe Operating Protocol
- Demonstrate a pro-social and role modelling approach to working in partnership with another approved DA Matters trainer
- State the importance of the DA Matters Change programme for police training being delivered by two trainers with backgrounds in Police work and DA specialist service provision.
- Describe the importance of completing the trainer Feedback Form for the DA Matters programme lead and how this contributes to Police force performance improvements
- Describe the role of a SafeLives DA Matters trainer within the national trainer pool as it relates to the quality and assurance training standards
- Describe the quality and assurance procedure and all its components
- Demonstrate understanding of the invoicing and payment system for DA Matters trainers
- Describe the importance of taking part in the pre-brief and debrief calls during the delivery phase of DA Matters
- Describe the DA Matters evaluation process and the trainer responsibility in relation to it

The DA Matters First Responders training

Aim: To provide police officers and staff with knowledge and understanding of the dynamics of domestic abuse, the reality of domestic abuse and how to respond consistently and effectively to reports of domestic abuse Objectives:

- Define what is meant by the term 'domestic abuse'
- Explain the role of the first responder and the DA Matters Champion in the DA Matters Change programme
- Explain what is meant by the term "coercive control" and how to discover evidence of coercive control using appropriate questions and communication techniques.
- Describe the effect of multiple controlling behaviours on victims, other vulnerable persons and children impacted by the perpetrator's behaviour
- Identify why victims can find it difficult to leave an abusive relationship and how hard perpetrators work to resist their victim leaving an abusive relationship
- Identify the stages of change a victim experience when in and preparing to leave an abusive relationship and how this impacts on them as responders
- Describe what intervention responders can provide to a victim at each stage of an abusive relationship
- Specify the link between coercive control and stalking and harassment

- Explain best practice when recording and reporting the responses to domestic abuse incidents which can maximise evidential value and minimise victim blaming
- Describe the tactics perpetrators may use to manipulate first responders
- Describe the importance of securing evidence at the scene of a domestic abuse incident
- Identify the need and potential options to safeguard victims and children

The DA Matters Champions training

Aim: To provide learners with an introduction to the role of a DA Matters Champion and the confidence to practice in the role

Objectives:

- Define the role of a DA Matters Champion within their force area
- Outline the tasks carried out by a DA Matters Champion within their force area
- Outline what areas of practice and what attitudes a DA Matters Champion will support their colleagues in
- Recognise the signs and effects of vicarious trauma, occupational burnout and compassion fatigue and describe tactics to combat these conditions
- Define the GROW model of hot debrief/observation/feedback
- Perform hot debriefs using the GROW model of coaching
- Outline the preferred DA Matters Champion response to a disclosure of domestic abuse by a colleague.
- Demonstrate increased knowledge and awareness when dealing with Male Victims, LGBT*victims, and Forced marriage victims of DA
- Define and understand Economic abuse and the role it plays within DA
- Outline how Perpetrators of DA can present as victims of DA

The SafeLives DA Matters Sustaining the Change Workshop for senior leaders

Aim: To provide strategic leads with an insight into the DA Matters First Responder and Champions training events and look at ways their force can sustain the change achieved by the training and health check elements of the programme.

Objectives:

- Describe the evaluation outcomes from the DA Matters Change programme delivery relating to their force area
- Describe what frontline officers believe would help them give the best service to families experiencing DA in relation to their force area
- Describe the recommended actions applicable to their areas of command and make suggestions on meeting those recommendations using national best practice
- Describe the role of the DA Matters Champions and outline how they can support this role and those that carry out the role
- Describe how they will sustain the change in behaviour, attitude and knowledge in their area of responsibility

- Identify and describe how they might use officers/staff within their employ to safely use their lived experience to shape internal and external service provision around DA

The SafeLives DA Matters Evaluation

Aim: A two-phase evaluation is used to measure how the training has been received and to understand additional learning and barriers for frontline officers.

Phase one is carried out on the training day through a discussion exercise and completion of survey included some open-ended questions for detailed feedback. The force receives a full written report with a breakdown of responses including:

- What change frontline officers feel could help them to respond better in domestic abuse situations conducted at the start of each session
- Their level of understanding both before training and after training against each of the programme objectives
- Whether they feel the training will change how they perform their role
- Whether it will change how they respond to victims
- Would they recommend training to a colleague
- Additionally, Champions are asked whether the training will help them to support and offer development opportunities for colleagues

Phase two is carried out six months post training with a questionnaire sent to all officers who provided their email address at the end of training. It focuses on how the training has impacted their practice, and any positives and barriers to implementation. The force receives a full report detailing the breakdown of responses as well as an analysis of these qualitative elements. If there is an area of specific interest for a force, then we are able to add an additional question to the follow up evaluation.

Ongoing support

Ongoing support is provided by way of a secure group within an online community platform where DA Matters force leads, trainers and Champions can obtain further training opportunities, access to national best practice and liaise with other Champions and professionals countrywide. An established and active network of leads within each adopter force is coordinated by SafeLives to help provide consistency of approach for the role of the Champion and continue to drive the attitudinal change. This is achieved through discussion of topical issues, help to resolve problems and sharing of good practice. This network also meets in person bi-annually. Adopter forces are offered additional training workshops for officers and staff designed for use as part of CPD events, developed and based specifically around training need identified through the leads network.

Outcomes:

- Improved Champions Network by providing help and support when setting up or maintaining a Champions network

- Improved knowledge of police response to DA in UK by providing access to Champions and professionals in other force areas
- Improved knowledge on all aspects of responding to DA by provision of a community platform full of resources aiding response to DA
- Improved consistency of national response to DA by police by provision of access to a network where good practice is shared to help resolve problems
- Improved workforce knowledge of specific sections of and topics around DA by providing access to workshops developed for use in CPD events based on identified training need