Tewkesbury Community Safety Partnership

DHR- Ann

Death- September 2015

Review Concluded-April 2018

Final

Independent Chair –Deborah Jeremiah

Contents

APPENDICES

Tribute to Ann

Ann was a mother, sister, auntie and a good friend to many people. She was a very well established and much loved class teacher and school governor for many years and had shown exemplary teaching and dedication to her profession. She was a conscientious and exciting teacher who helped many hundreds of children find their potential. She was an accomplished cook and had previously pursued a career as a chef, often taking her skills into the classroom for all to enjoy. She was a strong and loyal friend and had many hobbies and interests such as her passion for singing in the local choral society. Ann was a warm and caring person with a huge personality and an infectious laugh. She was committed to children's sporting achievements and was herself very keen on keeping fit and enjoyed going to the gym where she had achieved completing a triathlon for charity. Ann leaves a huge gap for family and friends and will always be warmly remembered and very sadly missed by all those whose lives she touched with her sparkle, humour, care and compassion.

The Independent Chair and review panel would like to express deepest and heartfelt condolences to Ann's family and friends for their loss.

1. Preface

1.1 This report of a Domestic Homicide Review (DHR) examines county and agency responses and support given to Ann, a resident of Tewkesbury prior to the point of her death.

1.2 In addition to agency involvement the review will also examine the past to identify any relevant background or pattern of abuse before the homicide; whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer. Pseudonyms are used throughout the report.

1.3 The circumstances leading to this review are that Ann was murdered at home by her husband, Fred. On consideration of the circumstances by the Community Safety Partnership it was agreed this met the criteria for a Domestic Homicide Review.

1.4 The review will consider agency contact/involvement with both Ann and Fred with a focus upon the period from December 2013 to September 2015. That is not to say that earlier information will not be included where this might provide important context for the review. The most relevant time has transpired to be in September 2015.

1.5 The key purpose for undertaking a DHR is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely as possible, professionals need to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.6 The review has been led by an Independent Chair who has no association with the agencies or organisations concerned and one who has been trained in the process prescribed by the Home Office to conduct Domestic Homicide Reviews.

1.7 The Chair would also like to thank the review panel from a range of organisations and agencies who have cooperated and assisted with the review as well as those staff who supported the review from an administrative perspective.

2. Timescales

2.1 The Home Office Statutory Guidance advises that where practically possible the Domestic Homicide Review should be completed within 6 months of the decision made to proceed with the Review. Due to unforeseen circumstances of which the Home Office are aware this was not possible.

2.2 The Home Office were notified of the DHR on 21st October 2015.

2.3 The criminal proceedings concluded in March 2016.

2.4 The DHR panel met on five occasions for the DHR. The final meeting was on 11th September 2017.

2.5 Family members were consulted for the proposed final report between October 2017 and April 2018.

2.6 Any learning identified during this review will have been actioned by the agencies without waiting for publication and indeed a great deal of positive development work is noted in the report which is relevant to the facts and learning in this review.

3. Confidentiality

3.1 The findings of this review are restricted to only participating officers/professionals, and their line managers at this point before it is quality assured by the Home Office.

3.2. The content of the overview report and executive summary has been anonymised to protect the identity of the victim, perpetrator, relevant family members and others. The family will be advised as to the publication date of this review and have been given the opportunity to consider this report and input further before the report was submitted for quality assurance.

4. Methodology

4.1 This review is guided by:-

- The processes outlined in the Home Office multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2013 and latterly the new guidance issued in December 2016.
- Learning from other Domestic Homicides Reviews and Serious Case Reviews of child death/vulnerability across the UK
- The cross government definition of domestic abuse (April 2013).

4.2 Terms of Reference

4.3 On considering the death and the circumstances the Terms of Reference were agreed as follows:-

4.4 Whether in all the circumstances at the time, any agency or individual intervention could have potentially prevented Ann's death.

4.5 Review current responsibilities, policies and practices in relation to victims of domestic abuse – to build up a picture of what should have happened and review national best practice in respect of protecting adults from domestic abuse.

4.6 Examine the roles of the organisations involved in this case; the extent to which Ann and Fred had involvement with those agencies, and the appropriateness of single agency and partnership responses to this case to draw out the strengths and weaknesses.

4.7 Establish whether there are lessons to be learnt from this case about the way in which organisations and partnerships carried out their responsibilities to safeguard and protect the wellbeing of the victim.

4.8 Identify clearly what those lessons are.

4.9 Identify whether, as a result, there is a need for changes in organisational and/or partnership policy, procedures or practice in the county in order to better safeguard victims of domestic abuse.

4.10 Consider how services can detect risk in a domestic relationship, especially when outwardly it may look that all is well?

4.11 How can services that support family and friends share information that an individual may be at risk within their relationship?

4.12 How can services support employers and colleagues to share any relevant information that may indicate domestic abuse or risk?

4.13 What is the best practice professional response when an individual contacts the police exhibiting unhappiness around their relationship and possibly seeking help?

4.14 How can services support couples with serious relationship difficulties to navigate through this safely?

4.15 How can services support and safeguard an individual who may need to leave the relationship?

5. Involvement of Family, Friends, work colleagues, neighbours and Wider Community.

5.1 Information from family, friends and neighbours was gathered through numerous sources. Regard was given to the advice and guidance contained in the Advocacy After Fatal Domestic Abuse[1] and Home Office leaflet for families and this was provided to further aid the family's understanding and inform them of this support. The family chose not to have an expert advocate. The Terms of Reference were explained to them at the outset. The family did not meet the review panel preferring to input via the Chair and by telephone as was their wish. This was the most convenient medium particularly for one family member living outside the UK.

5.2. This review also used the principles of family involvement as contained in the research[2] for involving families to ensure a sensitive, structured and well prepared approach for initial contact, negotiation, information gathering and feedback throughout.

5.3 The trial statements were all made available and they contained information from a wide range of colleagues, friends and neighbours. Ann and Fred's daughter, Sue contributed greatly to the review. The couple did not have a large family but Ann's brother contributed also. Some close relatives declined and that decision is to be respected.

5.4 Ann and Fred had both lost their parents. Fred himself was also approached to contribute but to date has not wished to engage.

5.5 Some family members felt unable to input into the review and this has to be respected. This may limit the review in that not all perspectives have been captured but the panel have been able to build a reasonable profile of Ann and Fred's relationship and their life together and the extent of their support networks. Ann had a strong and varied network of friends and colleagues with whom she had confidantes. Ann had a positive social life outside the marriage with keen interests in singing and being a member of a gym. Fred had a much smaller network and his main support outside the marriage was from their daughter Sue.

5.6 As stated, the report has been shared with the family and this was in private with plenty of time to consider he report and suggest amendments. This took some time as not all family members are UK based.

6. Contributors to the Review

6.1 Contributors to this review include the review panel with their consideration and deliberations on the information being brought forward to the review which includes IMR's and supporting documentation.

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[1] www.aafda.org.uk

[2] Morris,K.,Brandon,M and Tudor,P. (2012) A Study of Family Involvement in Case Reviews: Messages for Policy and Practice BASPCAN ISBN 13 978 085358 287 8

The panel members were independent to the review, with the exception of the head teacher, who was Ann's employer and therefore knew her professionally. This panel member was included due to significant knowledge in relation to the circumstances of the case and the level of involvement the school had with Ann. The IMR and report was however independently reviewed by the County Council Education Team and LADO to ensure a level of independent scrutiny.

6.2 Most questions arising were answered by members of the review panel, IMR authors or frontline professionals. This did include the expertise of GDASS; the DASV coordinator and legal guidance around solicitors' duties around domestic abuse. GDASS is the Gloucestershire Domestic Abuse Support Service and is a county-wide service designed to reduce the level of domestic abuse and improve the safety of victims and their families. They operate in all districts offering a variety of support programmes for women and men over 16 years old experiencing domestic abuse. There is also a DASV (Domestic Abuse and Sexual Violence) service in Gloucester and both feed into the strategy and development work for Domestic abuse in the County.

The Chair also sought advice from a senior professional in education around school HR processes, safeguarding staff and management of domestic abuse concerns around employees in schools.

6.3 The IMR authors were provided with and followed the IMR template from the Home Office guidance as well as a checklist of what makes a good quality IMR. There was also a presentation delivered on the overarching process for the DHR and support around IMR's.

6.4 Individual Management Reviews (IMR's) were provided from:-

Gloucestershire Constabulary
Gloucestershire Education Authority
2Gether NHS Foundation Trust
Mythe Medical Practice (Primary Care)
Severn Vale Housing Association

6.5 An integrated chronology was also produced and the timeline in this report is drawn from that.

6.6 The IMR's were produced as requested and the Chair and Panel wish to thank the authors for these and for attending the panel meetings to present the IMR's and answer questions from the panel. On request some authors produced further information to sit behind the IMR and to clarify where necessary. It should be noted that the Housing IMR was later found to be incorrect having been prepared against the wrong individual. This error was subject to internal governance processes at the housing provider as an information breach. The IMR's were relatively brief and limited in number given that Ann had no contact at all with virtually any agency and Fred's contact was very minimal.

7. Review Panel Members

7.1 The DHR review panel is set out below-

Deborah Jeremiah, Independent Chair
Team leader, Gloucestershire Domestic Abuse Support Service (GDASS)
Detective Chief Inspector Public Protection, Gloucestershire Constabulary
Head Teacher Gloucestershire Education Authority
Safeguarding Lead, 2Gether NHS Foundation Trust
County DASV Strategic Coordinator, Public Protection Constabulary
Head of Community Services, Tewkesbury Borough Council
Housing Manager, Severn Vale Housing Association (stepped down after first panel meeting)
Named GP for Safeguarding Adults and Children, NHS Gloucestershire CCG

7.2 The panel consisted both of agencies that had some involvement with Ann and Fred but also those who have wider knowledge of working in the field of domestic abuse and have specific responsibilities around this. NHS England were invited to be part of the review panel but declined.

7.3 The panel met five times.

8. Author of the Overview report

The Independent Chair is also the author of the review report and has a health and legal background. She has completed the requisite training for conducting DHR and has also attended update training, the most recent in April 2017. She has been conducting DHR's since 2008. She is not in the employ of any agency involved in the review now or historically. She is fully independent of the Community Safety Partnership.

9. Parallel Processes

The only parallel process for this death were the criminal proceedings. There were numerous individuals who gave evidence into the trial whose statements and information provided was shared with the Independent Chair and this information is included in the review.

10. Equality and Diversity

10.1 Ann was 56 at the time of her death and Fred 54. Their ethnicity is white British.

10.2 The review adheres to the Equality Act 2010. All nine protected characteristics were considered by the panel. None were of concern or relevance to the circumstances of the deaths. The practices of agencies were carefully considered to ascertain if they were sensitive to the nine protected characteristics of the Equality Act 2010, i.e. age, disability, gender re-assignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, sex or sexual orientation.

10.3 The review panel considered all equality aspects and there is no information or inference in any records or other information to indicate that any incidents were motivated or aggravated by, ethnicity, faith, sexual orientation, gender, linguistic or other diversity factors.

11. Dissemination

Until such time as the report is deemed adequate within the Home Office quality assurance process the report will remain restricted. It will however be shared with the family prior to publication and in the manner as stated above.

12. Background Information

12.1 Ann and Fred lived in Tewkesbury. Fred owned their house in his sole name. Ann and Fred had been married for 30 years at the time of her death. For some years prior to Ann's death, the marriage had become more difficult and Ann was in the process of divorcing Fred at the time of her death. They were effectively living separate lives at this point but there were no domestic abuse factors that had come to the attention of the statutory agencies. Their only child, a daughter (Sue) was at university living away from the family home at the time of Ann's death. However Sue was in regular contact with her both her parents. Sue lived in a house owned by her mother and that was her accommodation while at University.

12.2 Ann was employed as a teacher at a local school and Fred had a number of jobs but his employment had decreased during the two years prior to Ann's death.

12.3 During the early hours of the date of death, a telephone call was received by the local police from Fred stating he had murdered his wife. Police attended the home address and found Ann, with a fatal head injury. CPR was attempted but Ann was pronounced dead at 5.09am. A two page letter had been left on Ann's back authored by Fred conveying his distress in his relationship with Ann and that she was leaving him. The details of the note has been omitted from this report in respect of and in accordance with the wishes of Ann's family.

12.4 At 6.55am police located Fred. On arrest he was found with cuts to his arms. He took police to the weapon he used to murder Ann. He pleaded guilty to the murder and said he attacked her after discovering she was having an affair and she would not consider reconciling and wanted a divorce. He also said that Ann wanted to sell the home that their daughter was living in and in effect make her homeless. He described the act as "an out of body experience" and he could

not stop himself. Fred pleaded guilty and was sentenced at a plea hearing on 12th February 2016. Fred was jailed for life and told he would serve a minimum of 11 years and nine months.

13. Overview

13.1 In more recent years before her death, Ann's colleagues and friends observed some discord between the couple at social events and Ann was conveying an increasing unhappiness in the marriage. This became much more intense in the few months before Ann's death with an escalation in the last month. Around a month before her death, Fred became aware Ann was having a relationship with another man. Fred told his GP and a police call handler that he was devastated about this and did not want the marriage to end. Fred was dependent upon Ann emotionally, practically but also financially. Fred was working less due to a physical health problem. There was also a major disagreement around the property where Sue was living as Ann wished to sell this and Fred disagreed stating that Sue still needed the property in which to live as she was still at University. This contention was never resolved and Ann sold the house in which Sue was living having offered alternative arrangements to Sue for the duration of the time she had left at University.

13.2 In September 2015 Ann became increasingly concerned about Fred's behaviours at home and told many colleagues and friends about this. This is evidenced by statements provided to the police and also information coming into the review from IMR and from panel discussions. These concerns were conveyed by Ann as informal discussions with a number of colleagues, the volume and content of which has only become fully apparent after Ann's death. It is fair to say that no one person had the full picture. Ann also spoke to friends outside work in a similar vein and they also gave her support and advice. Ann stated the behaviours included Fred trying to restrict her movements and finances; checking up on her at work; watching her closely at home; inappropriate sexual behaviour and a threat to her that she needed to be careful when sleeping. At the time Ann shared this with her colleagues but also close friends outside work. Ann did not share this information with the police or any other agencies.

13.3 Some colleagues did advise and signpost Ann to more formal advice around Fred's behaviours and on more than one occasion suggested to her she leave the house as the separation was clearly very challenging. In the context of divorce proceedings the panel were told that Ann said she had been advised to remain in the matrimonial home to protect her assets.

13.4 Fred rang the police on early September 2015 and spoke to a call handler for a considerable amount of time about his feelings and the difficulties in the relationship, expressing sadness around the situation. During this call he did not threaten Ann or present as aggressive or of concern. Therefore the police call handler did not initiate any other actions or a DASH.[3]

[3] The DASH form is a nationwide tool created in 2009. The DASH checklist was created by Laura Richards, BSc, MSc, FRSA on behalf of the Association of Chief Police Officers and in partnership with Safe Lives, a national charity dedicated to ending

13.5 Fred had suffered with depression in the past related to difficult life events and attended at his GP surgery two days later. He was clinically assessed for depression as he said he was experiencing low mood and said "his world had collapsed". The GP concluded he would benefit from some primary mental health team support but he declined. The plan was for a review three weeks hence.

13.6 Ann and Fred's disagreement about the house where Sue was living continued. Fred vehemently disagreed that the house should be sold while Sue still needed it but Ann needed to purchase another home as she had agreed that Fred would stay in the matrimonial home. Ann told colleagues that she was in fact supporting Sue in securing alternative accommodation.

13.7 Fred informed some colleagues at his place of work that Ann was divorcing him and was worried about the financial implications. There were no concerns there that Fred posed any threat to Ann by his employer or colleagues.

13.8 In the days leading up to Ann's death, Fred was openly telling neighbours that Ann was divorcing him and the neighbours had no concerns about Fred's demeanour or health. Fred said to one neighbour when he was asked how he was coping, he replied "a bit murderous, a bit angry".

13.9 Fred was served with the divorce papers the day he killed her.

13.10 Fred murdered Ann in the early hours of the morning.. When Sue arrived at the home and saw police present her first thought was that her father had killed himself as he had not been coping with the prospect of the divorce and Ann actually leaving the matrimonial home. She was shocked that her father had harmed her mother.

13.11 The timeline below sets out an overview of key dates lifted from the integrated chronology and where the DHR has focussed its consideration around learning points in accordance with agency contacts. The agency contacts were minimal and do not paint a picture that we often see in DHR of many contacts where agencies may be involved over some period of time. There were however some concerning behaviours being described by Ann to colleagues and friends particularly in September and that is the most significant period and demonstrates escalation. The exact dates of some of the conversations are unknown as these were informal discussions and not documented or passed on to any agencies at the time. Most have come to light after Ann's death.

13.12 It should be noted that both Ann and Fred had some historic involvement with mental health services. However this was some years previously and was not indicative of any enduring mental health issues. In Fred's case he had experienced a previous depressive episode in 2012, with some paranoia and

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domestic abuse. Its purpose is to capture information and to assess level of risk around incidents of domestic abuse, stalking, harassment and honour based violence.

persecutory feelings due to stressful life events. The stress related to concerns around his daughter at university, pressure at work and grief following the death of a parent. This was not an ongoing feature and he had not had any contact with mental health services for some years.

Date	Event
December 2014	Fred was noted to be low in mood at Ann's work Christmas social event. Described as having his "head in his hands" Fred's father had recently died.
22 January 2015	Fred saw his GP for hip pain review. Tramadol (a strong painkiller) was provided.
1 May 2015	A work colleague attended a concert where Ann was singing and noted discord between Ann and Fred.

Early September 2015	Ann complained to colleagues about Fred and that he was not working enough hours and sticking to a job. She stated he was following her to the gym and watching her at home.
Early September 2015 **Key event 1**	Ann was distressed at work and told colleagues she woke up and found Fred standing above her while she was in bed and that he had threatened her to be careful when she was sleeping. Ann said she had been advised by her solicitor to stay in the matrimonial home to protect her assets.
Early September 2015 **Key event 2**	Ann asked to speak to a Parent Support Advisor (PSA) at her work for help and advice. She described Fred taking her house and car keys for long period and that she would be locked out of her house at times.
Early September 2015 **Key event 3**	Ann tells the PSA that Fred had taken her cards and blocked her access to all bank accounts. Ann tells the PSA that Fred had taken her passport and birth certificate.
Early September 2015 **Key event 4**	Ann told colleagues that Fred said he would have her mentally assessed and she believed he could and would this. He also accused her of having child pornography on her laptop.
Mid September 2015	Fred rang the Head at Ann's school at home which was highly unusual and tells her that Ann is having an affair. Fred was ranting and accusing the man of being interested in young children. He thought the man was also employed by the school.
Mid September 2015 **Key event 5**	Fred contacted the Police Force control room and discussed his marriage breakdown at length with a call handler for the police.
Mid September 2015 **Key event 6**	The Head spoke to Ann who denied allegations being made by Fred. Ann did later admit she was in a relationship with someone else. Ann was advised to take spare clothes and keys to a friend's house in readiness to leave. Ann agreed. Ann told colleagues she was looking for flat to move out and did not want to go home. She also told the Head Fred was coming into her room at night behaving in a sexually inappropriate way. Ann told her colleague she was putting her chest of drawers in front of her bedroom door to stop Fred.

Mid September 2015 **Key event 7**	Fred was seen by his GP. He told the GP that he had found out his wife was cheating on him. Fred said his world had collapsed, and he still loved her. The GP assessed Fred and suggested he have some support from a mental health nurse but Fred declined.
Late September 2015	Ann told colleagues Fred was pestering her with texts and she was definitely separating from him and she was asking her solicitor to write to him to stop him.
End September 2015 **Key event 8**	Ann tells staff Fred would be receiving the divorce papers and she was scared to go home.
End September 2015	As Ann left work she commented to a colleague she was going "back to hell." Later Ann text a colleague and was positive and looking to the future.
End September 2015	Ann is murdered by Fred.

14. Analysis

14.1 Agencies were asked to provide chronologies and IMR's of their involvement with Ann and this will be considered through the key events as set out in the timeline.

14.2 The focus for this section of the report therefore will be an analysis of the response of the agencies involved and why decisions were made and actions taken or not taken as indicated by the IMR's but also from further information within the review.

14.3 The review panel has made every effort to avoid hindsight bias and has viewed the case and its circumstances as it would have been seen by the individuals at the time.

14.4 KEY EVENT 1- Ann distressed at work but stated she had been advised by the solicitor to stay in the matrimonial home.

14.5 Ann worked as a senior teacher in a school and she had a good rapport with her colleagues, some of which she had worked with for many years. Some of her colleagues had met Fred at school events and socially. The new academic term started in early September 2015 after the long summer break and this was when Ann started conveying to her colleagues that her relationship with Fred was very difficult and the marriage was coming to an end.

14.6 That September in the month leading up to her death Ann's relationship with Fred deteriorated further and his behaviour escalated**.** While Ann was carrying on with her work competently she was privately emotional at work and at times visibly distressed. Throughout she maintained a professional demeanour with the children and fulfilled her role to an excellent standard.

14.7 Ann said to colleagues that the advice from her solicitor was not to leave the matrimonial home as this would best protect her financial assets. Having sought guidance on this advice it is apparent that the legal advice to stay in the matrimonial home is common advice. However it is said in the expectation that the other party to the relationship will move out once it is apparent that the relationship is ending. It is not known what, if anything Ann said to Fred about moving out at any stage and in fact just before the divorce papers were served Ann had secured a flat and so she was in the process of leaving the matrimonial home.

14.8 Solicitors working in the field of divorce are familiar with domestic abuse and the challenges posed by separation but there is no defined guidance on what advice should be given where it may not be safe for one party to remain in the matrimonial home or that such a risk can escalate.

14.9 The reality is that it depends upon the client seeking the divorce to appraise the solicitor of any risk factors. This also assists the solicitor to appreciate if other orders should be sought such as injunctive relief or remedies under harassment law. Solicitors are not under any duty to make a risk assessment before giving this advice and it is for the client to decide in all the circumstances to follow this advice or not.

14.10 It should also be noted that in 2015 although the concept of coercive control was not new this was not yet an offence in its own right and was less understood.

14.11 Learning Point 1 – Family lawyers risk providing inappropriate advice if they do not explore the dynamics of the relationship and if there are any features of domestic abuse and risks that may be attached to that dynamic.

14.12 **KEY EVENT 2- Early September 2015**

14.13 Ann was distressed at work and told colleagues she woke up and found Fred standing over her while she was in bed and threatened her to be careful when she was sleeping.

14.14 The specific date of the above conversation is unclear as records were not made (this was an informal conversation between colleagues/friends rather than professional advice being given) Ann's distress impacted upon her at work in that she was tearful and upset but she was also professional in her role.

14.15 Ann stated Fred was following her to the gym and watching her at home. This behaviour was a clear indicator that Fred was behaving in an inappropriate manner toward Ann.

14.16 At this point although what Ann was saying was disturbing this was considered a personal matter and not something that raised safeguarding concerns for Ann or to trigger colleagues to take advice from Human Resources (HR) or any external agencies. Colleagues sought to support and show sympathy. At the

time it was not seen as any serious indication of a direct threat to Ann. Some colleagues did however warn Ann to be careful. Ann was not signposted at this point to the police or any other agency as this was seen as a personal matter on which Ann had confided to a colleague and that Ann was considered to be managing the situation. Ann did not consider herself to be in imminent danger and she was intending to return home. However while the school did not have a policy around employees and domestic abuse, the school did have posters up around the school educating around domestic violence. It has been fed into the review that any HR service supporting the school would not have acted on any disclosures Ann was sharing unless it had been affecting her performance. This is an concerning distinction in that a victim may well be performing well in their job but can still be experiencing domestic abuse and be at risk.

14.17 The main practical guidance for employers where there are concerns for an employee who may be a victim of domestic abuse is a Department of Health and Safe Lives guidance document – "**Responding to Colleagues experiencing Domestic Abuse: Practical Guidance for line managers, Human Resources and Employee Assistance Programmes."** This is supplemented by the Equality and Human Rights Commission (EHRC) and Chartered Institute of Personnel and Development (CIPD) guidance "**Managing and Supporting Employees Experiencing Domestic Abuse" 2013.** Both contain a helpful checklist and risk assessment guidance for employers who may have concerns about a colleague.

14.18 However schools do not operate a human resources function in the same way as many employers. Schools buy in a service for HR from Gloucestershire County Council (GCC) for disciplinary processes and formal support. In this case, the process was that colleagues who were concerned about a colleague could to go to the Head Teacher, who in turn could seek advice from HR if there was something specific she needed them to do with the information. In this case GCC's HR were not aware of the concerns around Ann or the National Guidance.

14.19 **Learning Point 2** – The national guidance was not considered or followed in this case as Ann herself did not raise matters with HR and colleagues saw her difficulties as a purely personal matter.

14.20 KEY EVENT 3- Early September 2015

14.21 Ann described Fred taking her house and car keys.

14.22 Ann told a colleague that Fred was taking her house and car keys for long periods and that she would be locked out of her house at times. She also said that in the summer school holidays that Fred had taken her mobile from her for about a week. The panel agreed in the review that this was evidence of coercive behaviour.

14.23. The colleague advised Ann to keep spare house and car keys at work. Neither the colleague nor Ann saw Fred's behaviour as abusive as such though it was clearly controlling. Ann was not expressing that she felt scared of Fred or had

been physically harmed by him though his behaviours were clearly controlling in nature and sought to restrict Ann and coercively control with whom she could make contact and her ability to leave the house. This behaviour was not identified as coercive control at that time.

14.24 It should also be noted that in 2015 although the concept of coercive control was not new this was not yet an offence in its own right and the panel agreed it was less understood in all its subtleties. There is now an offence of coercive control in its own right such is the current understanding that this behaviour subjected upon another is a high risk indicator for harm. Coercive control within relationships is more widespread than initially thought. [4]

14.25 Domestic abuse can take many forms but as our national understanding of domestic abuse has grown a feature of controlling behaviours has emerged including a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacity for personal gain, depriving them of means needed for independence, resistance and escape and regulating their everyday behaviour.[5]

14.26 The core elements of 'power and coercive control' have been recognised by those working in the domestic abuse field for some years. However, it is only in more recent years that coercive control has been better defined and been made an offence in law. The law was enacted to make this a criminal offence in December 2015 after this death occurred, but the core principles of coercive control were known before that time though teachers and educational professionals would not have been sited on this in terms of staff but domestic abuse was seen more around safeguarding children.

14.27 Warning signs and behavioural techniques of abuse considered to be components of coercive control before and after this became an offence include:-

- Unpredictable mood swings- switching from charm to rage
- Excessive jealousy and possessiveness
- Preventing a partner from seeing family or friends.
- Constant criticism including putting the partner down in public
- Control of the partner's money
- Control over what the partner wears, who they see, where they go, what they think
- Exerting pressure on the partner to have sex against their will
- Random and unexpected use of violence to frighten and subdue partner

[4] Myhill, A, Measuring coercive control: what can we learn from national population surveys? (Violence Against Women 21(3), 2015, pp. 355-375)

[5] www.stopvaw.org/uploads/evan_stark_article_final_100812.pdf

14.28 While Ann was not expressing fear on this occasion some of the behaviours from Fred at this time were as listed above and indicate the development of a more abusive relationship.

14.29 Learning point 3: the lack of understanding and awareness of coercive control at the time (this was an ongoing, developing area) acted as a barrier to fully recognise Fred's behaviour toward Ann as abusive. Safe Lives provide useful and informative information for professionals in this area including for those in education. [6]

14.30 KEY EVENT 4- mid September 2015

Ann told the same colleague Fred had taken her cards and blocked her access to all bank accounts. Ann also said that Fred had taken her passport and birth certificate.

14.31 This was reported by Ann informally to the colleague who initially sought to give practical advice around the bank accounts. Ann was advised by the colleague that Fred may be lying and that she could go the bank and sort it out. Ann was advised she could reapply for any cards cancelled but Ann doubted this.

14.32 This provides further direct evidence from Ann of coercive control from Fred. Ann was advised by the colleague to go to a solicitor during school hours. She was also advised to go and stay with a friend and not go home. The staff member googled the name of a solicitor and also gave Ann a list of what she may need from the home and the GDASS number. GDASS is Gloucestershire Domestic Abuse Support Service. [7]. It later transpired that Ann did not see a solicitor that day or contact GDASS. Had she done so it is highly likely that a risk assessment such as DASH would have been completed.

14.33 The use of a DASH risk assessment or similar tool assists professionals understanding of the degree and nature of conflict in the relationship.

14.34 The DASH form is a nationwide tool created in 2009. The DASH checklist was created by Laura Richards, BSc, MSc, FRSA on behalf of the Association of Chief Police Officers and in partnership with Safe Lives, a national charity dedicated to ending domestic abuse. Its purpose is to capture information and to assess level of risk around incidents of domestic abuse, stalking, harassment and honour based violence.

14.35 The DASH form can be completed by any professional. It is best practice that a professional completes a DASH if someone may be a victim of domestic abuse. There are two enhanced sections of the form which must be completed if there is a positive answer to the question "Is there any other person that has threatened you or that you are afraid of?" This enhanced section has a further ten questions and goes into much greater detail of the victim's circumstances.

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[6] www.safelives.org.uk/.../Coercive%20control%20guidance%20for%20MARACs.pdf

[7] http://www.gdass.org.uk

The other enhanced section is with reference to stalking and honour-based crimes.

14.36 The quality of the risk assessment is determined by the comprehensive collection of information attached to each question and on the summary page at the rear of the form. The risk management framework of the DASH is based on there being three levels of risk to the victim.

14.37 Standard – current evidence does not indicate likelihood of causing serious harm

14.38 Medium – There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change of circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, and drug or alcohol misuse.

14.39 High – There are identifiable indicators of enduring physical and psychological serious harm. The potential event could happen at any time and the impact would be of serious harm (Home Office 2002 and Offender Assessment System 2006): "A risk which is life threatening and/or traumatic and from which recovery, whether physical or psychological, can be expected to be difficult or impossible".

14.40 The majority of DASH forms are completed by the police. No professional can compel an individual to agree to this risk assessment but it does serve as a structured method to capture information about a relationship and can be shared with other agencies.

14.41 The colleague was not aware that Fred and Sue had discovered that Ann was in another relationship nor of the conflict around Sue's accommodation. Ann did not share this information but nevertheless the colleague took the matter very seriously and gave Ann advice as well as practically helping her to take steps to keep safe. GDASS explained in considering these exchanges that it is not uncommon for referrals to come to them after informal disclosures and that it is possible to complete a DASH assessment in retrospective or seek more formal assistance from GDASS. It is acknowledged that the informal nature of such disclosures to friends and colleagues does act as a barrier to a more formal response and the matter is unlikely to reach a HR level unless the individual's performance is affected and raises concerns. Despite the turmoil Ann was expressing in her relationship with Fred she was able to perform her professional duties to a high standard. Colleagues and friends acted as confidantes and without Ann's consent or request would not share the information so as not to betray the confidence and put their relationship with Ann in jeopardy.

14.42 **Learning Point 3**: where an employee continues to disclose concerning information about an intimate relationship, it would be good practice to confer with a safeguarding lead and/or HR. If possible a risk assessment such as

DASH can should be completed after a referral to an appropriate agency e.g. GDASS for advice.

14.43 KEY EVENT 4- mid September 2015

14.44 Ann told a number of colleagues that Fred was threatening to have her mentally assessed and she believed he could and would do this. Ann also stated that Fred accused her of having child pornography on her laptop (which was untrue).

14.45 This was on the same date but as a separate conversation. This was evidence of malice from Fred in seeking to humiliate Ann knowing that such allegations toward a teacher working could be catastrophic both to her reputation and livelihood and raise questions about their mental health.

14.46 Colleagues told Ann to be careful that Fred did not have access to her laptop to incriminate her. The Head followed the Allegations Policy at the school and had no concerns around Ann's conduct nor believed the allegations and saw them as malicious. HR was not involved nor were they aware that as an employee Ann was being accused of these serious allegations within a context of experiencing other concerning behaviours from a spouse. On taking advice for the review it was advised that the Head acted appropriately in following the Allegations Policy and that HR would not necessarily be involved in such allegations. In this case HR were not involved so the context of the allegations toward Ann by Fred were not discussed at this level.

14.47 No one person at Ann's place of employment or indeed Ann's friends and family had the overview of the various disclosures Ann was making informally at work and many came to light in their entirety after her death. While each disclosure in their own right thus far was concerning even if just seen as isolated events, given the picture of accumulation of what Ann was telling colleagues, HR's involvement may have been useful to support her. This support could have been to support Ann to realise the behaviours being exhibited by Fred amounted a domestic abuse and seek appropriate external help in a sensitive manner. HR had a legitimate reason to be involved in the face of serious allegations.

14.48 Learning Point 4-. Employees when faced with concerning information from a colleague around possible domestic abuse or any other safeguarding matter should utilise HR for advice and support or encourage the colleague making the disclosures to do so. Safeguarding leads can also support.

14.49 Key Event 5 -mid September 2015

14.50 Fred contacted the Police Force control room and discussed his marriage breakdown with a call handler for the police.

14.51 The review team were unable to listen to the call as the audio was unclear but were provided with the lengthy transcript. The call handler shows immense empathy toward Fred as he explains about his relationship with Ann and his

sadness at her wanting to end the marriage. Fred did not demonstrate any aggression toward Ann though at one point does say that he would like to challenge the third party with whom Ann was in a relationship. The call handler reasoned with Fred to stay calm to ensure he did nothing that would make matters worse for his situation. The call handler encouraged Fred to accept the situation and try and move on with his life. The call did not trigger a DASH assessment, as this was not a call featuring concerns around domestic abuse which is a reasonable conclusion. The call is ended amicably with Fred communicating in a calm and rational manner.

14.52 The police IMR for this review did consider this call. Fred had no previous relevant contacts with the police and there was no history of domestic abuse call outs to the family home. No third parties had expressed concern to the police and neither they nor the call handler were aware of Fred's behaviours as observed directly by Ann's colleagues and from her accounts. Importantly it should be noted that Ann had not reported anything to the police of her concerns and challenges with Fred.

14.53 Learning Point 5-The management of the call handler is an example of good practice.

14.54 Key event 6- mid September 2015

14.55 Ann told a colleague she was looking for a flat to move out and did not want to go home. She also told the Head Fred was coming into her bedroom at night and behaving in a sexually inappropriate manner. Ann disclosed she was putting a chest of drawers in front of her bedroom door to stop Fred.

14.56 This is a clear indication that Ann felt unsafe at home and was reluctant to go home. Ann was advised by a colleague to get out of the home. Ann did not take this advice but she was progressing with some haste around a divorce and finding alternative accommodation. Ann had previously told colleagues that her solicitor had advised her to stay in the family home to protect her assets. Ann appears to have been heavily influenced by this advice on an ongoing basis though had clearly resolved to move out as she was actively looking for new accommodation.

14.57 This was the first time Ann had disclosed that she needed to physically block Fred having contact with her in the family home. Fred's behaviour was becoming more disturbing. Separation points for relationships can represent a high risk factor. [8]

14.58 Learning Point 6- This aligns with learning point 2 and 4 and the need to use national guidance for employers.

[8] (Smith et al. 2011) – there is an elevated risk of abuse around the time of separation (Richards 2004).

14.59 Key event 7- mid September 2015

14.60 Fred was seen by his GP as he felt low in mood.

14.61 Fred went to see his GP. This was a longer than usual consultation and lasted around 25 minutes. GP consultations are usually scheduled for 10 minutes. Fred presented one month after finding out that Ann was in another relationship. The GP was attentive to Fred and considered Fred's expressed emotions and feelings not unusual given his circumstances of a marriage breakdown. There was no depression risk tool used but the GP did enquire as to how Fred was functioning day to day and he was eating and sleeping okay which was reassuring and went against a major depressive illness. The GP also explored with Fred any thoughts of self harm and any suicidal ideation which Fred denied. Fred was assessed as not being any risk to others. The offer of a primary mental health team referral to see the practice mental health nurse for further support was declined. The appropriate counselling services were signposted to Fred e.g. Relate. Fred was asked to come back to see the GP for a review in three weeks which is good practice.

14.62 Fred was calm throughout the consultation despite saying things like "my world has collapsed". The common tool to assess depression was not used (PHQ9)[9] but this is not essential and the GP did spend quite some time with Fred assessing him professionally. In this review the GP explained that the PHQ9 tool does have some limitations and clinical judgement is important. The GP thought that Fred had perhaps attended to "offload" and Fred said he might look into counselling but that things were very difficult for him.

14.63 Guidance from the National Institute for Health and Care Excellence, NICE[10] summarises the approach to recognition and treatment of depression. This does not prescribe a specific tool to assess depression.

14.64 The GP was shocked that Fred went on to murder Ann. While it is acknowledged that no formal tool was used to assess Fred's mental state sound professional judgement was used to provide Fred with advice and further support. Fred chose to decline that and there is no indication that he lacked mental capacity and so he was fully entitled to make a choice on that.

14.65 It is not unusual for those struggling with a life event such as divorce to visit their GP. Fred did not attend his GP again. Historically Fred had very little contact with his GP with only 5 face to face consultations between 2013 and 2015 and none for Ann. Fred's were more related to a painful back.

14.66 There were 111,169 divorces in England in 2014.[11] There does not appear to be reliable and relatable statistics in the UK on what percentage of those involve spousal death by the hand of the other spouse. At the time of the GP seeing

9. Kroenke K, Spitzer RL, Williams JB; The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001 Sep 16(9):606-13.

[10] NICE (2014:4)

[11] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/divorce/bulletins/divorcesinenglandandwales/2014

Fred he was not considered as being a risk to himself or others and this is not an unreasonable conclusion given how Fred was presenting and also the GP made time to assess Fred fully. As a professional, the GP could not have possibly predicted the tragic event to come.

14.67 Ann did not attend her GP or any other health professionals during the salient time and appears to have used colleagues and friends for support.

14.68 Learning Point 7: When presented with a patient advising that their relationship has broken down, clinicians should attempt to obtain as deep an insight as possible and relevant into the impact of the relationship breakdown on others within the family. The review panel however were satisfied that the GP took all appropriate to steps to assess and support Fred.

14.69 KEY EVENT 8 – late September 2015

Ann left work she told staff Fred would be receiving the divorce papers that day and she was scared to go home.

14.70 Ann said to a colleague she was fearful of going home and Fred's reaction to the divorce papers being served. Colleagues told her to be brave and she was doing the right thing.

14.71 We know in relationships which become unhealthy and abusive where one party does not accept the end of a relationship that the physical separation point can be a high risk factor to domestic abuse and death.

14.72 However not all separations will be high risk or involve domestic abuse or coercive behaviours. In this case no agency had information at the time to be able to profile the risk and this would have required Ann to have sought help. Ann herself while making many concerning disclosures to friends and colleagues she, nor they saw her at risk of any physical harm. Only friends and colleagues were aware of concerning disclosures and information being shared by Ann. Other than her solicitor Ann was not seeing any other professionals. This was not a situation where the police had been called to incidents and a DASH completed in that context nor was there the sort of apparent known incidents which may have enabled Ann to have taken some sort of legal action. Ann's motivation and focus was to end the marriage and live elsewhere and for Fred and Sue to live in the matrimonial home. No one at the time could have predicted Fred's reaction when the actual separation was imminent.

14.73 Learning Point 8- the impact of a separation point in an intimate relationship where there is non acceptance by one party and evidence of previous abusive behaviours may increase risk of harm.

14.74 Given the multi-agency involvement, both Ann and Fred were not coming to the attention of services or agencies in a concerning manner. Professionals had little opportunity to consider the relationship in terms of domestic abuse and risk. Ann was making disclosures but to colleagues at work and her close friends outside work. Certainly professionals could have no regard to

established typology such as that identified by Johnson. [12] Whilst referred to in this paragraph, the typologies identified have no bearing on the facts of this case and have therefore not been explored further.

14.75 Fred murdered Ann while she slept.and gave himself up to the police after notifying them of his actions.

14.76 Sue also inputted that she did not see her mother at risk of physical harm, saw Fred as vulnerable and struggling to come to terms with the end of the marriage, and that he was angry and disappointed at Ann selling the house she was living in. Sue said that her father was shocked that her mother was in another relationship but she could never have imagined him harming Ann.

14.77 The review panel concluded that the death could not have been foreseen.

15. Conclusions and DHR Recommendations

15.1 The conclusions of this review and associated recommendations are set out below. The action plans are set out at **Appendix 2**

15.2 Learning Point 1 - Family lawyers risk providing inappropriate advice if they do not explore the dynamics of the relationship and if there are any features of domestic abuse and risks that may be attached to that dynamic.

15.3 **Recommendation:** The Community Safety Partnership should write to the Law Society and Association of Family Lawyers bringing their attention to this DHR and ask them to consider issuing appropriate guidance.

15.4 **Learning Point 2** – The national guidance was not considered or followed in this case as Ann herself did not raise this with HR and colleagues saw her difficulties as a purely personal matter. As stated schools are atypical in that they do not necessarily have HR on site and tend to buy this service in on a needs basis.

15.5 Recommendation**:** The Community Safety Partnership should use this review to highlight to multi-agency employers/employees multi-agency that there is national guidance in place and that HR can support around concerns of an employee experiencing domestic abuse.

15.6 **Learning Point 3** - the lack of understanding and awareness of coercive control at the time (this was an ongoing, developing area) acted as a barrier to fully recognise Fred's behaviour toward Ann as abusive.

However, it should be noted that since that time and during the review, a Multi-Agency Awareness Campaign was run for the 16 days of action (25th November-10th December 2016) with a focus on coercive control. Awareness posters were distributed across the county, with social media and website content promoted. A conference was held for professionals and districts undertook their own

[12] 2 Johnson, M.P. (2008) A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence. The Northeastern series on gender, crime, and law. Lebanon, New Hampshire, US: UPNE

awareness raising activity within their area to promote the messages of what Coercive Control is and how victims can seek support and report the abuse they are experiencing.

As part of the DASV Implementation Plan in the County, a training pathway is being developed which will provide guidance to professionals on the level of training required based on job role, alongside an awareness of the training available in the County. Current DA training available through the GSCB covers awareness of Coercive Control as well as understanding other risk factors associated with DA; this training is continually reviewed and updated.

15.7 **Recommendation**: The Community Safety Partnership and County endorse the ongoing development of multi-partner awareness training around coercive control.

15.8 **Learning Point 4** Employees when faced with concerning information from a colleague around possible domestic abuse or any other safeguarding matter should utilise HR via the Head Teacher for advice and support or encourage the colleague making the disclosures to do so.
The development of a countywide DASV Concordat is underway, being led by the County DASV Strategic Coordinator and supported by partner agencies involved in the DASV Implementation Group. These guidance documents (in particular the DA guide) have a section on responding to colleagues and employees experiences.

This Concordat will ask agencies to sign up to an overarching policy statement setting out key commitments to tackling DASV in the County. To support agencies in fulfilling their commitments, a range of template polices will be developed, and a set of guidance documents are currently being drafted. At the time of writing, final draft guidance documents have been circulated for comments covering:

- Identifying and Responding to Domestic Abuse
- MARAC Guide and operating protocol
- Identifying and Responding to Stalking/Stalking Clinic protocol

The plan is to currently have the final full concordat, with all its supporting materials, published by the end of 2017. All information will be made available through the County Website for DASV www.glostakeastand.com The plan is to have all the final concordat documents published and signed up to during 2018, but many guidance documents have already been published to support agencies in responding to DA in Gloucestershire.

15.9 **Recommendation:** The Community Safety Partnershipand County to endorse and support the Concordat and take steps to highlight the role of HR in supporting employees who may be experiencing any element of domestic abuse. This should include seeking assurance that HR leads are aware of national guidance and also encourage the use “Working Without Fear” from the Hollie Gazzard Trust (**see at Appendix 1**) as a practical and up to date toolkit.

15.10 **Learning Point 5**: The management of the call handler is an example of good practice. Reviews should highlight and share examples of good practice.

15.11 **Recommendation:** This good practice should be shared and commended across the partnership.

15.12 **Learning Point 6** This aligns with learning point 2 and 4 and the need to use national guidance.

15.13 See **Recommendation** for 2 and 4.

15.14 **Learning Point 7:**

15.15 **Recommendation**: This review acknowledges this insight by primary care and adopts the IMR recommendation but the GP in this case demonstrated good and thoughtful practice.

APPENDIX 1

Extract from Working Without Fear Programme- Hollie Gazzard Trust

Working Without Fear

Domestic Abuse and Stalking in the Workplace

As an employer, would you know the signs,
or understand what your legal obligations are?

Would you like to increase the performance management of your staff?

In England and Wales domestic abuse costs £1.9billion a year in lost economic output. This hard-hitting fact is due to decreased productivity, administration difficulties from unplanned time off, lost wages and sick pay. Domestic abuse can impact negatively on an employee's health and wellbeing. It can also impact on staff morale as well as organisational image and reputation. One of the main action points in the Domestic Homicide Review, following the murder of Hollie Gazzard, was that businesses need to be engaged and proactive on this subject.

Nick Gazzard at Nick Gazzard Consulting (NGC), developed Working Without Fear, a tailor-made programme, following the murder of his daughter Hollie, to ensure that companies recognise what domestic violence and stalking is, realise the implications for their businesses, and respond appropriately so that staff and organisations are protected. Working Without Fear is integral to this and enables companies to understand the individual challenges they may face with regard to staff wellbeing. Benchmarking, measuring outcomes and tracking progress all contribute to adding real value to the business and ensure that companies attract, retain and develop the best possible employees at all levels.

Businesses can make a difference

Business activities extending across all departments face challenges in marketing, sales, project management, product management and many more. Networking, negotiations, partnerships and cost savings are ever-increasing in importance in today's competitive marketplaces, however, by including ideas, initiatives and activities aimed at enhancing the business and making it better, business development can flourish. This also includes staff wellbeing. It is often employees that can help to develop the business by offering ideas, suggestions and changes. By better understanding the needs of employees, this can be rolled out through strategic partnerships and business decisions to improve performance management and ultimately the overall business objectives.

NGC will assist in establishing best practice when it comes to strategies supporting the wellbeing of staff suffering from domestic abuse and stalking. However, through training and inviting staff to help improve personal and business potential, as ideas and initiatives mature, the company will be able to build its business development in this area through internal expertise, supported by staff.

Implications for staff

With research showing that one in four women and one in six men will experience domestic abuse at some point in their lifetime, it is likely that the majority of workplaces employ staff who have experienced, or who are currently experiencing abuse and/or stalking, as well as employing those who are perpetrators.
What Working Without Fear does is to highlight what desperately heinous crimes domestic violence and stalking really are and the devastating impact they have on individuals and companies alike. Abuse and stalking is what goes on behind 'closed' doors. It's what keeps these crimes secret. It's never one isolated incident, it's a pattern of never-ending coercive control and violence against the victim. It takes huge bravery to admit to being abused or stalked and it takes great courage to try and leave a desperate situation. Experts are currently calling the scourge of domestic violence an epidemic. It's an epidemic that's claiming the lives of two women every week at the hands of perpetrators and between four and ten women who take their own lives each week as a result of the trauma they've suffered. The cost to individuals is priceless, while the cost to companies is worth billions.

Businesses have a legal and moral obligation to protect their staff.
If you know how to recognise the signs, know what your legal and moral responsibilities entail, and provide the best place possible for your employees to work, you can:

Attract quality staff
Improve rates of sickness and/or absenteeism
Encourage punctuality
Decrease attrition rates/staff turnover
Raise staff morale
Improve performance quality
Better manage performance management

3

The programme consists of the following:

Introductory session

This will highlight:
Raising awareness of Domestic Violence and Abuse (DVA), coercive control and stalking in the workplace
Identify the responsibilities of the employer
Outline the negative impact it has on the business
Highlight the ongoing risks to the business
Detail the benefits of training to the business
Linking training with positive outcomes for the business
The session will last 45 minutes and 12 copies of the Working Without Fear company information booklet will be provided.

The Pledge

The Working Without Fear Pledge enables employers to demonstrate their commitment to the fact they recognise they have a duty of care towards their employees by providing a working environment that is safe and secure, and encourages their staff to disclose any domestic abuse or stalking that they might be experiencing.
Creating a culture that builds an environment of Trust and encourages disclosure.

Policy Template

The programme will also provide a policy template for domestic abuse and stalking that will complement existing HR policies.

Training workshops

NGC can also provide a variety of workshops for champions, Line Managers and HR staff. Each workshop lasts an hour and can be delivered to up to 12 individuals at a time.

Workshop 1: Understanding and spotting the signs

This workshop will cover coercive controlling behaviors, how to Identify the signs and dispel the myths.

4

Workshop 2: The impact on individuals and the organization

Workshop 2 will outline the risks to individuals and the organisation and provide insight into how they can be assessed, managed and avoided.

Workshop 3: Supporting an individual and taking action

Would you know how to support someone suffering from domestic abuse and/or stalking? This workshop provides proven strategies for making a difference that matters.

Workshop 4: Raising awareness, creating policy and implementation

Creating a policy and implementation are covered in this workshop, combined with raising awareness from the outset.

Workshop 5: Responding to a Disclosure

(Designed for line managers)
Considerations and how to handle a disclosure will be covered and implemented.
All training workshops will include an evaluation at the end and attendees will be provided with a copy of either the Working Without Fear guidance for line managers or, guidance for employee's booklet (whichever is appropriate). All attendees will receive a certificate of completion.

Details of local and national support services and helplines will be provided along with awareness raising posters.

Employees and businesses matter

An appropriate plan enabling you to reach attainable future goals through tailormade strategies is all part of the Working Without Fear programme. It is important for companies to understand that by creating an improved culture of wellbeing for staff, the positive benefits to individuals and the organisation provide tangible real value in today's competitive marketplace.

Nick has been commissioned by Gloucestershire's Police and Crime Commissioner to help businesses understand their duties and to help them implement policies and procedures effectively. He also provides training for management and staff on how to identify those suffering from abuse, how to intervene earlier and provide a duty of care.

If you are interested in finding out more, please contact Nick Gazzard: nick@ngconsulting.org

APPENDIX 2

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
The Community Safety Partnership should write to the Law Society and Association of Family Lawyers bringing their attention to this DHR and ask them to consider issuing appropriate guidance.	Nationally	The Head of Community Services (TBC) to write letter and submit on behalf of the CSP	Tewksbury Borough Council/ Safer Gloucesters hire		Within 3 months of report publication	
The Community Safety Partnership should use this review to highlight to multi-agency employers /employees that there is national guidance in place and that HR can support around concerns of an employee experiencing domestic abuse.	Regionally	The Head of Community Services (TBC) will bring this to the attention of Safer Gloucestershire to consider how this action can be taken forward in a coordinated way across Gloucestershire.	Tewksbury Borough Council/ Safer Gloucester-shire	HCS to bring to attention of SG Develop a plan to promote HR guidance and link with County DASV Coordinator in relation to Concordat development work and awareness raising activity	Ongoing from date of publication	

The Community Safety Partnership and County endorse the ongoing development of multi-partner awareness training around coercive control.	Regionally	Safer Gloucestershire to be approached to lead on the promotion of training pathway and commitment from agencies of their participation	Safer Gloucester-shire	Promotion of available multi-agency training and County Training Pathway. Commitment from agencies that staff will be appropriately trained and will have access to available training. Further promotion of Coercive Control awareness resources available on www.glostakeastand.com Link with County DASV Coordinator for strategic work and awareness raising.	Ongoing from date of publication	A Coercive control campaign was run during the 16 days of action in 2016. This campaign included a training conference for professionals, publication of resources and posters. MARAC/DASH training has been rolled out across the county and will continue; this features a segment on coercive control as a refresher to attendees. GDASS are regularly asked to attend team meetings to give talks about DA, and recently completed sessions alongside the DASV coordinator at the GSAB roadshows to raise awareness of DA and coercive control. Gloucestershire Constabulary conducted a DA campaign in mid-2018 aiming to raise awareness

						of the different types of DA, including coercive control. This included a range of social media content, radio adverts and newspaper adverts.
The Community Safety Partnership and County to endorse and support the Concordat and take steps to highlight the role of HR in supporting employees who may be experiencing any element of domestic abuse. This should include seeking assurance that HR leads are aware of national guidance and also encourage the use "Working Without Fear" from the Hollie Gazzard Trust (see at Appendix 1) as a practical and up to date toolkit.	Regionally	Safer Gloucestershire to discuss with the Hollie Gazzard Trust how best to incorporate this into the work and promotion of the trust. Safer Gloucestershire to sign up to and promote the DASV Concordat once published	Safer Gloucestershire	Awareness raising for 'working without fear' and consideration of how this can be adopted throughout the county. Publication of the full DASV Concordat and full agency sign up (linking with DASV Strategic Coordinator)	Ongoing from date of publication	The 16 days of action for 2018 focused on engaging with employers. Gloucestershire teamed up with Public Health England for the South West in their campaign, promoting the toolkit for employers, producing posters and a range of social media content. The campaign aimed to outline employer responsibility for responding to DA amongst their employees and provided them with the toolkit to support them. The DASV Concordat is now finalised and currently discussion is being had as to the best way to secure sign up across the county. The Concordat itself is a policy

				Ongoing monitoring of agencies commitment to key principles of the DASV Concordat (linking with DASV Strategic Coordinator and DASV Commissioning Group)		statement that outlines agencies commitment to tackling DASV. It is accompanied by a range of guidance documents, most of which are already published on www.glostakeastand.com; Identifying and responding to DA, Identifying and responding to Stalking, MARAC guidance and protocol, Identifying and responding to abuse in teenage relationships. Soon to be published: Identifying and responding to SV, Guidance on developing a DASV policy, training pathway/guidance and Identifying and responding to HBV/FM. Coercive control is a strong feature in all available DA training in the county. Training guidance has also been produced and will be published alongside the Concordat in the next few months.

						The Hollie Gazzard Trust continues to roll out working without fear to businesses across Gloucestershire and beyond.
The management of the call handler is good practice and this should be shared and commended across the partnership.	Regionally	Safer Gloucestershire to publicise this good practice to partner agencies.	Safer Gloucester-shire		Within 3 months of report publication	
This DHR outcomes should be shared with primary care clinicians	Local Regional	Sharing the DHR to increase awareness of the wider impact of Domestic Abuse and Coercive Control on all family members	Health (CCG)	GP Safeguarding Forum Regional Safeguarding Health Leads Forum	Within 12months of report publication	

APPENDIX 3

Source materials and references

- Policing Domestic Abuse: How To? 12th June 2015
- Morris,K.,Brandon,M and Tudor,P. (2012) A Study of Family Involvement in Case Reviews: Messages for Policy and Practice BASPCAN ISBN 13 978 085358 287 8
- www.aafda.org.uk
- University of Bristol. Who does what to whom: gender and domestic violence perpetrators- 2013
- Research report 55. Supporting high risk victims of domestic violence; a review of Multi-Agency Risk Assessment Conferences (MARACs) -July 2011
- Responding to domestic abuse: Guidance for General Practice- 2012
- Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, Home Office -2013
- Domestic Abuse risk factors and risk assessment: Summary of findings from a Rapid Evidence Assessment Levin Wheller and Julia Wire December 2014
- Domestic Violence and abuse: how health services, social care and organisations can respond effectively. NICE (National Institute for Health and Care Excellence) 2014,
- Home Office - Controlling or Coercive Behaviour in an Intimate or Family Relationship 2015
- Johnson, M.P. (2008) A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence. The Northeastern series on gender, crime, and law. Lebanon, New Hampshire, US: UPNE
- https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/divorce/bulletins/divorcesinenglandandwales/2014
- Smith et al. 2011) – there is an elevated risk of abuse around the time of separation (Richards 2004).
- Kroenke K, Spitzer RL, Williams JB; The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001 Sep 16(9):606-13.
- www.stopvaw.org/uploads/evan_stark_article_final_100812.pdf
- Myhill, A, Measuring coercive control: what can we learn from national population surveys? (Violence Against Women 21(3), 2015, pp. 355-375)