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GLOUCESTER CITY COMMUNITY SAFETY DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Report into the death of Daisy

In September 2020

Independent Chair and Author of Report: Mark Yexley

Associate, Standing Together Against Domestic Abuse

Date of Completion (sent to CSP)/: June 2023

Dedication from Daisy's family

I never thought I'd ever have to write a dedication to my baby sister, how do you express your feelings? When I remember Daisy I remember the kind loving and generous child who grew into a funny gregarious life loving adult. Daisy was a very talented hairdresser who is still missed by her old clients years after she stopped hairdressing they all say 'nobody cuts my hair like Daisy did' Daisy loved life, she loved going on holiday with her friends. She had good friends they house shared before Daisy bought her own house which she was so proud of, she took great joy doing the house up just as she wanted it to be. Daisy loved dancing, out every weekend her friends called her their dancing queen. Daisy loved to shop if she found a dress bag or shoes liked she buy them in every colour. Daisy loved cars especially classic cars and on more than one occasion she replaced a modern reliable car for a classic car, her favourite one was an Austin A40 she always said they were much more fun to drive. Daisy was such a whirlwind who seemed to be able rinse every ounce of joy out of life. Which makes very hard to understand how things turned out the way they have.

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1. Preface

1.1 The Review Process

1.1.1 This summary outlines the process undertaken by the Gloucester Community Safety Partnership (CSP) in conjunction with Safer Gloucestershire, Domestic Homicide Review (DHR) panel in reviewing the death of Daisy who was a resident in their area.

1.1.2 The name of Daisy's accommodation at the time of her death has been changed to protect the identity of residents and staff at the premises. The following pseudonyms have been used in this review to protect the identities of the deceased, other parties, those of their family members, and the Ex-Partner:

Name	Relationship to deceased
Daisy	Deceased
Petar	Ex-Partner
Sally	Sister of deceased

1.1.3 The death of Daisy was referred to the HM Coroner. An inquest was held in September 2021. The verdict of the Inquest was of 'suicide'. The medical cause of death was recorded as 'enveloping head in plastic bag'.

1.1.4 The process began with a police referral to the Community Safety Partnership in September 2020 when the decision to hold a DHR was made. All agencies that potentially had contact with Daisy and Petar prior to the point of death were contacted, asked to confirm whether they had involvement with them, and instructed to secure their records.

1.2 Contributors to the Review

1.2.1 This Review has followed the 2016 statutory guidance for Domestic Homicide Reviews which was issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. A total of nineteen agencies were contacted to check for involvement with the parties concerned with this Review. Nine agencies returned a nil contact, seven agencies submitted Individual Management Reviews (IMRs) and chronologies, one agency completed a short report and two agencies submitted chronologies only due to the brevity of their involvement. The chronologies were combined, and a narrative chronology written by the Chair.

1.2.2 The following agencies and their contributions to this review are:

Agency	Contribution
Daisy's General Practitioner (GP)	Chronology and IMR
Gloucester City Council Housing Team	Chronology and IMR
Gloucestershire County Council Safeguarding Adults Services	Chronology and IMR

Gloucestershire Constabulary	Chronology and IMR
Gloucestershire Multi-Agency Risk Assessment Conference (MARAC)	Short Report
Gloucestershire Domestic Abuse Support Service (GDASS)	Chronology and IMR
Gloucestershire Health and Care NHS Foundation Trust (GHC) Mental Health and Community Health Services	Chronology and IMR
Gloucestershire Hospitals NHS Foundation Trust (GHT)	Chronology and IMR
Daisy's Housing Provider	Interviewed
South Western Ambulance Service NHS Foundation Trust (SWAST)	Chronology Only
Victim Support	Chronology Only

1.2.3 *Independence and Quality of IMRs*: The IMRs were written by authors independent of case management or delivery of the service concerned. IMRs received were comprehensive and enabled the panel to analyse the contact with Daisy or Petar, and to produce the learning for this review. Where necessary, further questions were sent to agencies and responses were received.

1.3 The Review Panel Members

1.3.1 The Review Panel members were:

Name	Job Title	Agency
Gordon Benson	Quality Lead at GHC and a key member of the suicide prevention steering group	Gloucestershire Health and Care NHS Foundation Trust (GHC)
Fiona Bird	Specialist Safeguarding Practitioner	Gloucestershire Health and Care NHS Foundation Trust (GHC)
Emily Bolland	Community Wellbeing Team Leader and CPS Lead for Gloucester City CSP	Gloucester City Council
Jo Bridgeman	Specialist Nurse Safeguarding	Gloucestershire Clinical Commissioning Group (CCG)
Sarah Deo	Matron (first meeting)	Minor Injury & Illnesses Unit (MIiU), Gloucestershire Care Services NHS Trust

Heather Downer	Service Manager	Gloucestershire Domestic Abuse Support Service (GDASS)
Ieuan Edwards	Acting Director	MIND – Mental Health Charity
Liz Emmerson	Head of Safeguarding & Named Nurse for Safeguarding Children and Young People (From February 2022)	Gloucestershire Health and Care NHS Foundation Trust (GHC)
Alison Feher	Head of Safeguarding (Up to November 2021)	Gloucestershire Health and Care NHS Foundation Trust (GHC)
Tom Gillingham	Team Leader	Gloucester City Council Housing
Paul Gray	Team Manager	Gloucestershire County Council Adult Safeguarding Team
Paula Hannaford	Detective Inspector	Gloucestershire Constabulary
Sophie Jarrett	County Domestic Abuse and Sexual Violence (DASV) Strategic Coordinator	Gloucestershire Office of the Police and Crime Commissioner (OPCC) (shared post with the constabulary and county council)
Sarah Jasper	Head of Safeguarding Adults Services	Gloucestershire County Council
Serena Mees	Named Safeguarding Professional	South Western Ambulance Service NHS Foundation Trust (SWAST)
Angela Middlewood	Detective Inspector	Gloucestershire Constabulary
Mark Scully	Head of the Wiltshire and Gloucestershire Local Delivery Unit	National Probation Service
Wayne Stevens	Area Manager	Victim Support
Ann Thummler	Named lead for safeguarding adults	Gloucestershire Health and Care NHS Foundation Trust (GHC)
Jeanette Welsh	Adult Safeguarding Lead and Chair of the Safeguarding Adults Review Sub-Group for	Gloucestershire Hospitals NHS Foundation Trust

	Gloucestershire, Safeguarding Adults Board	
Moira Wood	Principal Social Worker for Adults	Gloucestershire County Council Adult Social Care (ASC)
Clare Woodhouse	Deputy Manager	Gloucestershire Domestic Abuse Support Service (GDASS)
Mark Yexley	Independent Chair	Standing Together Against Domestic Abuse

1.3.2 *Independence and expertise:* Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

1.3.3 The Review Panel met a total of four times, with the first meeting of the Review Panel on the 26 January 2021. There were subsequent meetings on 9 June 2021, 2 December 2021, a scheduled meeting for 22 February 2022 was cancelled due to ill-health. A final meeting was held on 22 July 2022. There was a delay between the first and second meeting as there were a number of other DHRs in the region, this resulted in an increased demand on the expert panel members who were required at multiple reviews. It was proposed by the CSP that the panel meetings were staggered in order to ensure each panel had focussed, expert representation.

1.3.4 The Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.4 Chair of the DHR and Author of the Overview Report

1.4.1 The Chair and author of the review is Mark Yexley, an Associate DHR Chair with Standing Together. Mark has received Domestic Homicide Review Chair's training from Standing Together and has chaired and authored 18 DHRs, including joint DHR/SAR. Mark is a former Detective Chief Inspector with 38 years' experience of dealing with domestic abuse. He was the head of service-wide Strategic and Tactical Intelligence Units combating domestic violence offenders, head of Cold Case Rape Investigation unit and Partnership Lead for sexual violence in London. Mark was also a member of the Metropolitan Police Authority Domestic and Sexual Violence Board and Mayor for London Violence Against Women Group. Since retiring from the police service, he has been employed as a lay chair for NHS Health Education Services in London and the South East. This work involves independent reviews of NHS services, training and selection for foundation doctors, specialty grades.

1.4.2 *Independence:* Mark Yexley has no connection with the Gloucestershire area. He retired from the Metropolitan Police Service in January 2011.

1.5 Terms of Reference for the Review

1.5.1 At the first meeting, the Review Panel shared information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from December 2016 to the date of Daisy's death in September 2020. This included the first known incident of domestic abuse between Petar and Daisy. Disclosure then established that they were seen as a couple in November 2016. The Terms of Reference were not adjusted but the author has considered all contact in November 2016. Agencies were asked to summarise any relevant contact they had had with Daisy or Petar before December 2016. This would include information on reported domestic abuse perpetrated by Petar on previous partners and recorded domestic abuse on Daisy perpetrated by another man.

1.5.2 Key Lines of Inquiry: The Review Panel considered both the generic issues as set out in the 2016 statutory guidance and identified and considered the following case specific issues:

- Analyse the communication, procedures and discussions, which took place within and between agencies.
- Analyse the co-operation between different agencies involved with Daisy / Petar [and wider family].
- Analyse the opportunity for agencies to identify and assess domestic abuse/adult safeguarding risk and links to MARAC processes.
- Analyse agency responses to any identification of domestic abuse and adult safeguarding issues.
- Analyse organisations' access to specialist domestic abuse and support agencies.
- Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues. This should also include the areas of Safeguarding Adults under the Care Act 2014, suicide/self-harm, repeat victim and repeat perpetrators.
- Analyse whether substance misuse impacted on Daisy's access to services.
- Analyse whether Daisy traumatic life experiences and potential for self-harm impacted on her access to services.
- Analyse whether Daisy's homelessness and housing needs impacted on her access to services.
- Analyse whether Daisy's mental health impacted her on access to services.
- Analyse whether the COVID 19 pandemic had any impact on access to services.
- Analyse whether Daisy could have been subject to economic/financial abuse.
- Analyse whether Daisy or Petar could have been subject to or experienced any unconscious bias in their contact with agencies.

1.5.3 To address specific issues in this case (including in relation to equality and diversity) the following agencies were invited to be part of the review due to their expertise even though they had not been previously aware of the individuals involved:

- MIND – the mental health charity; and
- Gloucester Suicide Prevention Panel Representative
- Change Grow Live - substance misuse service was invited to the meetings. They did not attend meetings and a recommendation has been included in this report to ensure that substance misuse services engage in future reviews.

2. Summary of Chronology

2.1.1 Prior to her relationship with Petar, Daisy had reported domestic abuse from a previous partner. She had also been referred to Multi-Agency Risk Assessment Conferences (MARAC) as being of 'HIGH RISK' of domestic abuse. There was also suspicion of economic abuse.

2.1.2 In 2012 Daisy was diagnosed with bipolar affective disorder.

2.1.3 In January 2015 Petar was arrested for assaulting a previous partner. Petar was alleged to have headbutted, punched and kicked his partner causing injury. The CPS made an NFA decision.

2.1.4 In March 2015 Daisy was referred to the Gloucestershire Health and Care NHS Foundation Trust (GCH) (Mental Health) Assertive Outreach Team (AOT) following an admission to an acute mental health hospital. She was supported by the AOT following her discharge from hospital in June 2015. Daisy was a GHC patient up until her death in 2020, receiving regular care and prescribed medication.

2.1.5 In November 2016 AOT noted that Daisy was in a new relationship with Petar. The couple initially lived together in a privately rented flat in Gloucester.

2.1.6 In December 2016 Daisy presented to her GP in a manic state. It was noted that her partner had told her not to take her medication. Daisy was detained under s. 3 Mental Health Act (MHA) 1983 for treatment in hospital. Daisy was admitted to hospital, as she was considered vulnerable due to her mental state and risk of abuse. Daisy later returned to Petar.

2.1.7 Whilst at the flat they went into rent arrears and were threatened with eviction. Daisy wanted to be rehoused with Petar, but the local authority only recognised her housing needs, not Petar's. Daisy was offered accommodation but refused it as Petar could not live with her. In December 2017 Daisy's family financially supported her for a few days, whilst she stayed, with Petar, in Bed and Breakfast (B&B) accommodation.

2.1.8 Daisy's GHC Care Coordinator (CC) approached a landlord, Pinewood, that provides housing including supported living packages for public services. The CC asked if they could take Daisy, with Petar, as a private tenant. In December 2017 Daisy moved into a room in a shared house as a private tenant. Daisy lived in a single room, with access shared bathroom and kitchen. Daisy was living independently and responsible for her own bills. She moved into the room with Petar from the outset and stayed with her until five days before her death.

2.1.9 GHC staff continued to treat Daisy at home. In February 2018 there were concerns of 'self-neglect' in relation to Daisy.

2.1.10 In April 2018 it was known that Petar had Daisy's bank card and driving licence. Daisy's family were concerned over Petar's access to Daisy's finances.

2.1.11 In September 2018 Petar sold Daisy's TV to pay for his father's hospital bills. Daisy would only leave her home to see GHC if Petar was with her.

2.1.12 On 18 July 2019 the CC reviewed Daisy's mental health risk assessment due to continuing concerns regarding her financial situation, risk from others was recorded as MEDIUM in the context of financial abuse and vulnerability. Daisy was not aware of her financial situation. Petar would frequently hold onto her bank card. On assessment it was noted that it was difficult to ascertain the current nature of the relationship, due to Daisy's lowered mood and reluctance to engage in conversations regarding finances or her relationship. There were concerns that she was being financially exploited by Petar. The Care Coordinator recorded that having a partner was highly important to Daisy; and any relationship break up previously had significantly impacted on the Daisy's mental health.

2.1.13 On 11 October 2019 GHC raised a Safeguarding Concern with Gloucestershire County Council (GCC). This was the first formal Safeguarding Referral to GCC. There was no DASH Assessment completed.

2.1.14 On 30 October 2019, the Gloucestershire CC Safeguarding Adults Team decided not to proceed to a Section 42 Enquiry. It was noted that Daisy did not consent for this to proceed and would not agree to workers seeing her bank account details. It was noted that there was 'limited evidence of financial abuse'. It was noted that her rent and bills were being paid, she had food and money left over from her benefits indicating limited evidence of financial abuse.

2.1.15 On 22 November 2019 Daisy called the police reporting a burglary. She said that an unknown male had stolen cash and pushed her down the stairs at the Pinewood address. A crime was recorded but it was noted that no statements were taken, as her 'story kept changing'. Petar asked to speak to officers alone. He told them he doubted the whole incident as Daisy suffered from paranoia and had mental health issues.

2.1.16 Following this incident Daisy was admitted to hospital. Daisy said she had another fall later the same night as she was hopping to the bathroom, hitting her shoulder. An X-ray confirmed a displaced fracture of her upper arm near the shoulder joint. Daisy did not feel able to cope at home and she was admitted. It was noted that Daisy was asked about possible domestic abuse without Petar being present. She said that her injuries were not caused by Petar. The injuries were not consistent with the fall being described by Daisy.

2.1.17 Daisy's sister Sally saw Daisy's bank statements and could see that Petar had Daisy's card and was spending her money. Sally contacted the bank and informed them of the circumstances. The bank decided to stop payments on the card.

2.1.18 On 16 December 2019 GCC Safeguarding Team recorded a Safeguarding concern on financial and physical abuse. This referred to the push down the stairs on 22/23 November 2019. A Section 42 Enquiry was commenced, to be led by GHC. The enquiry was closed in March 2020. It was noted that Daisy did not want any intervention. There were no referrals to specialist domestic abuse service, and no domestic abuse risk assessment completed.

2.1.19 GHC continued to see Daisy on a regular basis. Her family continued to have concerns on Petar's economic abuse. In September 2020 her CC saw Daisy and discussed her finances.

2.1.20 In September 2020, five days before Daisy was found dead, police were called to Daisy's home. A resident had heard arguing in Daisy's room and there was a possible 'domestic' taking place. Police heard arguing on arrival, but Daisy came out into the hallway and was quick to tell them there were no issues. The door to the flat was unlocked, and Petar was inside. He demanded Daisy go back into the room in quite an aggressive voice, pointing his hand back inside the room. Daisy then went into the room, followed by officers. Petar then pointed to the bed, in a very controlling manner and Daisy sat on the bed where he was pointing. He then said words similar to "tell them nothing has happened." Daisy then looked at the officers and said, "nothing happened." Daisy was spoken to on her own and said that Petar had argued with her and dragged her around her room. She picked up a knife with the intention of hurting herself.

2.1.21 Petar was arrested for Common Assault. Police completed a Risk Assessment and referred Daisy to MARAC. A Safeguarding Adult Enquiry also commenced.

2.1.22 Daisy declined to make a statement. The police made the decision to take No Further Action against Petar, this decision was made without reference to the CPS.

2.1.23 The police served a Domestic Violence Protection Notice (DVPN) on Peter. The DVPN is recorded as being issued, 'as a chance to provide Daisy protection and space to allow agencies to regain her life and health'. There was no reaction from Petar. It was explained to him that he was not allowed to contact Daisy.

2.1.24 Cheltenham Magistrates Court issued a Domestic Violence Protection Order (DVPO) To protect Daisy. The order lasted 28 days.

2.1.25 Daisy was visited by police, and GHC and she was generally unresponsive. The Duty Independent Domestic Advisor (IDVA) attempted to contact Daisy without success. Daisy did leave her room to spend time with Pinewood staff.

2.1.26 Five days after Petar had been taken from Pinewood, the AOT Support Worker attended Pinewood for their planned daily visit. They entered Daisy's room to find Daisy in her bed with a plastic bag over her head. The Support Worker was unable to wake Daisy and called for assistance from Pinewood staff. Pinewood staff called 999 for an ambulance. The ambulance crew were unable to revive Daisy and she was pronounced dead at her home.

3. Conclusions and Lessons to be Learnt

3.1 Conclusions

3.1.1 It is not the purpose of this review to establish the cause of Daisy's death or to attach blame to any person. The inquest has concluded that Daisy took her own life. This review was established to consider how agencies worked with Daisy and how we can learn and improve responses to domestic abuse.

3.1.2 Daisy's family have fully supported this review in the hope that it will somehow reflect her as a person. The family engagement with this review is intended to support the development of policies and processes to help other people experiencing, some of the issues in Daisy's life. This review is a learning process, and the aim is to share that learning across all agencies involved to improve services in the future.

3.1.3 The review has established that Daisy had a history of being economically abused by partners for many years, with a previous partner profiting from the sale of her home. This was followed by serious physical assaults. The start of Daisy's known mental ill-health coincided with this early abuse. Petar was arrested for domestic abuse against another woman before he was known to be in a relationship with Daisy. After Daisy started her relationship with Petar it was reported that Petar had told her not to use medication. Thereafter it appeared that Petar was controlling Daisy's finances. Daisy was admitted to hospital after giving inconsistent accounts for serious injuries. Her family reported that she was being financially exploited by her partner. Days before her death Daisy reported threats from Petar with a knife and the police intervened. At that point the person, who could be considered be controlling Daisy's life was removed. It could be seen that she was made reliant on her partner and then that controlling element in her life was removed. Daisy was left vulnerable and alone.

3.1.4 A significant number of victims of domestic abuse take their own lives.[1] The issue of suicide should be key for those responding to and managing domestic abuse. Studies have shown that almost 30 women attempt suicide every day as a result of experiencing domestic abuse. It is also estimated that that every week three women take their own lives. The DASH risk assessment considers suicide and self-harm, for victims. The link between mental ill-health and domestic abuse is also clearly recognised in guidance for healthcare professionals. Routine enquiry into domestic abuse is required in adult mental health services.[2]

3.1.5 In this case, Daisy's past experience of abuse was known by those caring for her. Domestic abuse from Daisy's current partner was suspected. Safeguarding enquiries and police investigations were conducted. Those investigations were conducted, and

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[1] "*Of women who have experienced domestic abuse in the last six months, 500 commit suicide every year. Almost 200 of those had attended hospital for domestic abuse on the day they died, (p.32) Department of Health Responding to Domestic Abuse – A Resource for Healthcare professionals*
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf

[2] Department of Health, *Responding to domestic abuse: a resource for health professionals* (March 2017) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf (accessed 7 Sept 2020) p. 32

completed, in isolation and without engaging with domestic abuse specialists or MARAC. The panel acknowledged that there was a spotlight on the work of an individual within the mental health team, who was considered to be managing a very challenging situation. The focus of a review should be around improvement and safeguarding. Safeguarding processes should not be reliant on the work of an individual, supervisory processes and practice should be in place to keep vulnerable people safe.

3.1.6 The review has established the need for greater multi-agency communication and joint planning. There is a need for information sharing across all agencies to inform risk assessment and investigation strategies. There is a clear need for supervisory processes to be reviewed, and audited, to ensure compliance across a number of key agencies, including NHS Mental Health, Adult Social Care, and the Police. Agencies with a responsibility for investigation must ensure that they consider the valuable support and expertise available within partner agencies including healthcare, housing, and domestic abuse specialists.

3.2 Key Themes and Learning Identified

3.2.1 **Safeguarding and Domestic Abuse** The Social Care agencies have primacy for investigations under the Care Act 2014. In conducting these investigations they should not act alone and must be supported by partners to ensure the safety of people in need of care and support. In this case the GHC were the lead agency for Safeguarding referrals arising from concerns that Daisy was being abused by Petar. They dealt with the investigations in isolation. There were no referrals to police, specialist agencies or MARAC. Just as agencies are required to support Childrens' Social Care in Children Act enquiries into child abuse, agencies with expertise in investigating domestic abuse should be required to support Adult Safeguarding enquires into domestic abuse. Those enquires should be based on joint strategies and shared responsibility for keeping victims safe. There were several agencies available to support Daisy in her social, medical and legal needs and those should have been included in a partnership strategy to support her from the outset.

3.2.2 This lesson translates into recommendations 2, 7, C, D, E, and O.

3.2.3 **Supervision and Support** There is a need for independence and expertise in managing domestic abuse in Safeguarding Investigations. The Safeguarding Enquiry was allocated to the person who had secured accommodation for Daisy with her partner. They had allowed that partner to be present throughout the majority of medical consultations and clinical reviews when there had been clear evidence that he had previously told her not to take medication. He was a known domestic abuse suspect and Daisy had suffered serious injury. GHC considered that they were balancing the risk that Daisy may have disengaged had they not worked with her. That risk could have been shared with engagement with police, housing, and domestic abuse specialists through a MARAC referral. The safeguarding investigation could have been managed and supervised independently, focussing on the patient and staying engaged with their healthcare. The introduction of IDVAs to NHS services will provide valuable independent expertise and support.

3.2.4 **This lesson translates into recommendations 2, 3, 6, 7, A, C, D, P, and Q.**

3.2.5 **Effective Criminal Investigation of Domestic Abuse** There is a need for police to effectively identify and then investigate reports of domestic abuse. There should be effective independent supervisory processes in place. In November 2019 police did not formally identify a serious assault as possible domestic abuse, when they suspected abuse was present. This was a key point at which there could have been risk assessment with referrals to specialist agencies and MARAC. In managing the assault immediately before Daisy's death, police acted swiftly to arrest the suspected perpetrator but he was released without any evidence being gathered from potential witnesses. There was reliance on protection orders rather than a specialist investigation. When dealing with domestic abuse, every opportunity to proactively identify and secure evidence should be grasped.

3.2.6 **This lesson translates into recommendations 5, H, I, K, and L.**

3.2.7 **Economic Abuse** It is clear that Daisy suffered significant financial loss over the years of abusive relationships. Family and professionals were concerned that she was being financially exploited by her partner in the period before her death. Economic abuse should be treated in the same way as any other form of domestic abuse, as opposed to treating it as a property crime. In dealing with physical abuse, professionals can move to a safety plan, but use of DASH can evidence economic abuse. This is an area where the referral to/or advice of specialist domestic abuse service is essential.

3.2.8 **This lesson translates into recommendations 4,6, I, and K.**

3.2.9 **Separation and Suicide** Agencies should have an increased awareness of the potential for suicide in people subject to domestic abuse and separating from their abusers. Separation is recognised in Risk Assessments, but this tends to focus on the increased risk of attack from a perpetrator following separation. In this case legal steps were taken to protect Daisy from her partner but she was still a risk to herself. The coercive controlling actions of perpetrators can socially isolate their victims. When that perpetrator moves on, they can leave a victim cut off. This can severely affect the victim's mental health and well-being. This lesson can be clearly seen in this case. It is essential that the risk of suicide is always considered in risk assessment and steps are taken to address the care and support needs of a victim. This requires a timely multi-agency approach to provide a network of support and access to specialist agencies.

3.2.10 **This lesson translates into recommendations 1, 3, 7, B, C, H, and P.**

3.2.11 **Trauma Informed Work** Daisy experienced serious physical and emotional trauma during her abusive relationships. The physical injuries were clear for agencies to see although Daisy did not always disclose the true cause of those injuries. Many women who have experienced such abuse and trauma will be likely to experience mental ill-health and substance misuse problems. Services need to be actively aware of this association with domestic abuse and provide services tailored to their needs and welfare.

3.2.12 **This lesson translates into recommendations 1, 3, 6, B, C, E, M, N, O, and P.**

3.2.13 **Housing** It was clear that housing was an issue for Daisy throughout the period under review. The prospect of being made homeless was a cause of stress for Daisy and was considered to have contributed to ill-health. Daisy was supported in her housing situation by mental health care providers, but Daisy's request to have Petar stay with her effectively blocked her access to social housing. Daisy eventually accessed private housing through contacts known to her care provider. Petar exploited Daisy's housing position in his economic abuse, staying with her as a couple whilst making his own single application for housing. Housing agencies are key strategic partners in domestic abuse strategies and private landlords should also be alert to the fact that tenants can experience domestic abuse.

3.2.14 **This lesson translates into recommendations 4, 6, and A.**

4. Recommendations

4.1 Multi Agency Recommendations (developed by the Review Panel)

4.1.1 The Review Panel has developed the following recommendations during this DHR. These are described in section 5 as part of the analysis.

4.1.2 These recommendations are also presented in the multi-agency recommendation action plan template in **Appendix 2**. Safer Gloucestershire is responsible for overseeing the development and monitoring of the action plan.

4.1.3 **Recommendation 1** That the Home Office consider research into the risk of suicide after separation for vulnerable victims where high level coercive control is present. If appropriate this could be included in domestic abuse risk assessments going forward.

4.1.4 **Recommendation 2** That the Department and Health and Social Care and Home Office draft guidance on how to effectively manage joint Safeguarding Adult Reviews and Domestic Homicide Reviews.

4.1.5 **Recommendation 3** That Safer Gloucestershire ensure a thematic review is undertaken. The aim of the thematic review should be to bring together the learning from all suicide reviews in the county and ensure links are made with the GSPPF to develop a multi-agency plan for local activity to respond to common themes and share learning. This work should link to the recent publication of the "Suicide Timeline" by the University of Gloucester.[3]

4.1.6 **Recommendation 4** That Safer Gloucestershire consider raising awareness with housing providers, including private landlords, on domestic abuse. This should include information on coercive and controlling behaviour and economic abuse. This would alert landlords that abusers may exploit tenants and sabotage housing. Landlords should be encouraged to make Third Party reports where appropriate.

4.1.7 **Recommendation 5** That the Gloucestershire Criminal Justice Board establish a process to independently review the quality of police investigations to ensure that Evidence Led Prosecution policy is being used in appropriate cases.

4.1.8 **Recommendation 6** That Gloucestershire Domestic Abuse Local Partnership Board ensure the findings from this review are considered in the ongoing review of the local training pathway to ensure appropriate training on economic abuse is available and that the county DA communications plan include measures for awareness raising.

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[3] Monkton Smith, J. Siddiqui, H. Haile, S. and Sandham, A. (2022) '*Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing, and intimate partner homicide'* University of Gloucester, *https://eprints.glos.ac.uk/10579/16/10579_Monckton-Smith_%282022%29_Home_Office_Report.pdf* (Accessed December 2022).

4.1.9 **Recommendation 7** That the Gloucestershire Safeguarding Adults Board review Safeguarding Referral Protocols to ensure that Domestic Abuse cases involving people in need of care and support are effectively risk assessed, reported, investigated and supervised in a timely manner. This must include a robust supervision and audit model to ensure that all actions in s. 42 Care Act 2014 enquiries are addressed within the agency designated to make the enquiry; and then supervised before case is closed at County Council level.

4.2 Single Agency Recommendations

4.2.1 The following single agency recommendations were made by the agencies in their IMRs. They are described in section 5 following the analysis of contact by each agency.

4.2.2 These recommendations are also presented by agency in the single agency recommendation action plan template in **Appendix 3**. These recommendations should be acted on through the development of an action plan, with each agency reporting on progress to the Gloucester CSP.

4.2.3 These are as follows:

Gloucestershire Adult Social Care Services

4.2.4 No single agency recommendations

Gloucester City Council Housing Team

4.2.5 **Recommendation A** Targeted training for key partner agencies to increase knowledge about housing and homelessness services. Particularly focusing on issues around domestic abuse and homelessness and when to make an approach. Partner agencies to be targeted as a result of this DHR are: mental health services, supported accommodation providers within community (not commissioned by City Council).

GDASS

4.2.6 No single agency recommendations.

GHC

4.2.7 **Recommendation B** Domestic Abuse specific training (including competition of DASH, MARAC and GDASS services) to be delivered by MHIDVAs to Wotton Lawn Hospital Teams, Recovery and AOT Teams.

4.2.8 **Recommendation C** Development of Trust wide Domestic Abuse Training Package. MHIDVAs to identify and train Domestic Abuse champions across mental health services. GHC to establish a joint clear process with GCC for the management oversight/supervision of section 42 enquires caused to be made by GHC and their relevant recommendations.

4.2.9 **Recommendation D** Re-introduce Trust Domestic Abuse Lead role that sits within the Safeguarding Team.

4.2.10 **Recommendation E** GHC to develop a robust system of support/oversight with Section 42 enquiries. This has been developed in communication with the GCC Safeguarding Team, and is now up and running.

GHT

4.2.11 **Recommendation F** To record the name of the person a patient attends hospital with, and the role of that person in the patient's life.

4.2.12 **Recommendation G** To record the name of 'boyfriends' (or other significant others) who have allegedly assaulted patients.

Gloucestershire Police

4.2.13 **Recommendation H** To review the VIST to ensure appropriate risk assessment submissions utilising the new DARA tool and to ensure officers are provided with appropriate training.[4]

4.2.14 **Recommendation I** Improvement on Domestic Violence Investigative Standards of Custody Sergeants. Custody Sergeant provided a training input around investigation standards, rationale recording and the importance of investigative excellence.

4.2.15 **Recommendation J** NFA Rationale to be recorded on the Custody Log. All Custody Sergeant and Supervisors provided an input around any custody decision to be recorded on the custody log prior to release. This will help negate any questions around disposal.

4.2.16 **Recommendation K** Refresher Training on Domestic Abuse Evidence Led Prosecutions. Training inputs and guidance to be rolled out to ensure awareness of all Officers and Supervisors is raised.

4.2.17 **Recommendation L** DVPN Training. Training inputs and guidance to be rolled out to ensure all Officers and Supervisors awareness raised.

[4] https://www.college.police.uk/article/police-better-equipped-spot-controlling-behaviour

NHS Gloucestershire

4.2.18 **Recommendation M** Practices will consider the vulnerabilities of patients with mental health issues when receiving a letter from the mental health teams and flag a patient as vulnerable when necessary.

4.2.19 **Recommendation N** GP practices to ensure that mental health and other vulnerability issues are considered as part of their DNA policy and appropriate contact made and support offered if necessary with the patient.

4.2.20 **Recommendation O** When a patient with vulnerabilities is to be discussed at a practice vulnerable adult/safeguarding meeting, the mental health practitioner working with that patient should be invited to attend.

4.2.21 **Recommendation P** Request that letters coming from secondary care (including mental health teams) clearly note concerns arising and any increase in risk assessment levels in BOLD and in the summary include GP actions.

4.2.22 **Recommendation Q** Ensure mechanism by which urgent concerns can be shared between Primary Care and Mental Health teams.