Safer Somerset Partnership

Domestic Abuse Death Review

Adam died June 2021

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Adam died June 2021

Chair and Author

Katie Bielec

Review completed

January 2023

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Safer Somerset Partnership, the independent chair and panel members want to offer their deepest sympathy and condolences to Adam's family and friends. The chair would also like to thank all those who contributed to the review, for their honesty, time, reflection, and support.

1. Introduction

1.1 This Domestic Abuse Death Review is a statutory requirement of Domestic Homicide Review (DHR) which will examine agency responses and support given to Adam (not his real name), a resident in Somerset prior to his death in June 2021.

1.2 Adam died as a result of suicide, he was married to Sarah (not her real name) and they had 2 children together. Both Adam and Sarah had made allegations of domestic abuse against each other, the marriage ended in the summer of 2020, but the couple remained living in the same house with the children until Adams death.

1.3 Due to the allegations of domestic abuse, Safer Somerset Partnership decided to carry out a Domestic Homicide Review in respect of the death of Adam. Due to Adam taking his own life the panel felt it appropriate to name the review as a Domestic Abuse Death Review rather than a Domestic Homicide Review.

1.4 The review will consider agency contact/involvement with Adam, his wife and their children between February 2017 and June 2021. Agencies were also asked to consider any events outside of these dates for this review should there have been any relevance.

1.5 Safer Somerset Partnership and the Independent Chair were informed by the Somerset Coroner in November 2021 that they had concluded that in June 2021 Adam intended to end his life. There are no other reports being conducted that impacted this review.

2. Glossary

2.1 **BRAG** A tool to risk assess and record all forms of vulnerability or safeguarding concerns. The outcome of the BRAG assessments helps determine immediate action as well as triage, signposting and/or refer to appropriate partner agencies. It should be used alongside other assessment tools (such as the DASH), and its use is subject to continual compliance monitoring via the Qliksense App.

2.2 **DASH RIC** national SafeLives[1] Domestic Abuse, Stalking and Harassment Risk Indicator Checklist, for practitioners to identify those who are at high risk of harm.

2.3 **HRDA** – High Risk Domestic Abuse daily meeting with partner agencies to discuss risks, creating an action plan to safety plan for the victim, children and intervention for the perpetrator.

2.4 **IAU** - Incident Assessment Unit assess all incidents to classify them in line with national requirements and undertake desktop investigations where no THRIVE factors are present.

2.5 IDVA - Independent Domestic Violence Advocate

[1] https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL_1.pdf?msclkid=770463f4ceac11ec8f0466908e13260a

2.6 **IMR** - Individual Management Reviews - Section 9 of the Domestic Violence Crime and Victims Act (2004)[2].

2.7 **LSU** - Lighthouse Safeguarding Unit a joint team supporting victims and witnesses of crime (including onward referral to other agencies and, where appropriate, being a point of contact during a Criminal Justice System processes) alongside safeguarding overview. It provides a streamlined approach to supporting individuals by improved ways of working with partners to safeguard the most vulnerable.

2.8 **MARAC -** Multi-Agency Risk Assessment Conference to discuss high risk domestic abuse cases.

2.9 **MISPER** - a term commonly used to describe a missing person.

2.10 **NCDV** – National Centre for Domestic Violence, a national emergency injunction service to survivors of domestic abuse and violence.

2.11 **NCRS** - National Crime Recording Standard

2.12 **OIC** - Officer in the Case.

2.13 **PNC** – Police National Computer.

2.14 **PND** – Police National Database.

2.15 **PPN** - Public Protection Notice embedded in Niche, summarising vulnerabilities of an individual, which then forms the basis for a risk assessment for that individual.

2.16 **SDASH** – Stalking DASH – A unique set of questions where there are concerns of stalking behaviour to assist professionals in evaluating risk and supporting professional judgement.

2.17 **SDAS** – Somerset Drug and Alcohol Service

2.18 **SIDAS** – Somerset Integrated Domestic Abuse Service

2.19 **Target Hardening** – Security equipment installed into victims' home to increase safety.

2.20 **THRIVE** – a nationally implemented risk matrix used to assess risk and determine response.

- Threat (who or what is the threat to?),
- Harm (what is the likely level of harm),
- Risk (what is the risk of the threat occurring),
- Investigative (what are the investigative needs and requirements),
- Vulnerability (of the person associated with the incident),
- Engagement (what is required).

3. Timescales

3.1 Safer Somerset Partnership received a Domestic Homicide Review Referral from Avon and Somerset Constabulary 4 days after Adam's death. The decision to carry out the review was made in July 2021, in September 2021, the Independent Chair and Report Author was

[2] https://www.legislation.gov.uk/ukpga/2004/28/section/9

commissioned with the aim of completing the review by April 2022, panel meetings were held in October 2021, January, March and May 2022.

3.2 The Home Office Multi-Agency Statutory Guidance for Domestic Homicide Reviews December 2016[3] in paragraph 46 that the target timescale for completion of the Review of six months may need to be extended in complex cases. Due to circumstances caused by a combination of the complexities of the case and impact of Covid-19 this has now surpassed the 6 months, which has been with the approval of the Panel and Safer Somerset Partnership

4. Confidentiality

4.1 In line with Home Office Statutory Multi-Agency Guidance paragraph 75, to protect the identity of the victim, perpetrator, relevant family members, staff, and others to comply with the Data Protection Act 1998, pseudonyms have been used. Due to no contact with family or friends Adam and Sarah was chosen by Safer Somerset Partnership and agreed by the chair and panel.

4.2 The sharing of information between agencies in relation to this review was underpinned by the Partnership Personal Information Sharing Agreement (PISA) which is in place to facilitate the exchange of personal information to comply with the requirements of Section 9 of the Domestic Violence, Crime and Victims Act 2004 to establish and coordinate a Domestic Homicide Review (DHR).

4.3 Adam was a 45-year-old and Sarah was 47 years old at the time of Adam's death both were white British.

4.4 Panel meetings are all confidential and any sharing of information to third parties can only be carried out with the agreement of the responsible agency's representative, the panel and chair.

4.5 The findings are restricted to authors of the reports, their managers and panel members until presentation to the Safer Somerset Partnership (SSP). Once agreed the Home Office will be informed and presented to the Home Office Quality Assurance Panel for final approval. Initial learning identified through the Review process will be acted upon immediately.

5. Terms of Reference

Aims of The Domestic Homicide Review Process

- Establish the facts that led to the death in June 2021 and whether there are any lessons to be learnt from the case about the way in which local professionals and agencies worked together to safeguard the family.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

To produce a report which summarises concisely the relevant chronology of events including:

- the actions of all the involved agencies.
- the observations (and any actions) of relatives, friends, and workplace colleagues relevant to the review

[3] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

- analyses and comments on the appropriateness of actions taken.
- makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they have experienced.

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

Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.
- Establish the facts that led to the incident and whether there are any lessons to be learnt from the case about the way in which local professionals and agencies worked together to support or manage the person who caused harm.

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

Scope of the review

The review will:

- Consider the period from February 2017 to June 2021 (this is intended to cover the period from when an incident occurred in Hampshire which led to a MARAC referral and when Adam moved to the Somerset area in February 2018) subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events that are relevant.
- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Domestic Violence Crime and Victims Act (2004) and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family, employers, neighbours, and friends to provide a robust analysis of the events. Taking account of the coroners' inquest in terms of timing and contact with the family.
- Aim to produce a report within 6 months of the DHR being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.
- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends, and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.
- To discover if all relevant civil or criminal interventions were considered and/or used.
- Determine if there were any barriers Adam or his family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
- Against the Equality Act 2010's protected characteristics.
- Consider what is 'good practice' for agencies to achieve in their response to domestic abuse for male victims.
- Is there a consistency in how agencies respond to victims of domestic abuse when both parties may present to an agency (possible "bi-directional abuse" and "counter-allegations"), is there any gender bias?

- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.
- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.
- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.
- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.
- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.
- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.
- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic, and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.
- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. What were the effects of the Covid-19 pandemic on relevant organisations? Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.
- Consider the impact of Covid-19 on the family and accessibility of services.

6. Methodology

6.1 Domestic Homicide Reviews became statutory on 13/4/2011 under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by

a) A person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship or

b) A member of the same household as himself/herself; held with a view to identifying the lessons to be learnt from the death.

6.2 The principles of the review have been followed in accordance with the Home Office Multi-Agency Statutory Guidance on the Conduct of Domestic Homicide Reviews – Revised Version – December 2016[4].

6.3 The purpose of a DHR is to:

- Establish what lessons are to be learnt from the domestic homicide/suicide regarding the way in which local professionals and agencies work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

[4] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

- Apply those lessons to service response, including changes to policies and procedures as appropriate, and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working;
- Contribute to a better understanding of the nature of domestic violence and abuse;
- Highlight good practice.

6.4 Research has been used within the analysis and referenced throughout the report.

7. Involvement of family and friends

7.1 Sarah was informed of the review by letter, email and via both schools. Information of AAFDA was provided, an introduction to the chair with several offers to meet in person (both schools were offered as a venue) or virtually.

7.2 Sarah acknowledged the review and explained to the school she did not feel able to take part. The offer remained open throughout the review process.

7.3 Adam is survived by 2 children; however, due to their ages the panel and chair did not feel it appropriate to approach them as part of the review.

7.4 Further enquires were made to identify friends and family of Adam; contact was made with the coroner who was unable to provide any family contacts, and although professionals believe Adam had a brother no contact details were able to be ascertained. The chair worked with the Police to identify any additional contacts who knew Adam or Sarah (such as neighbours or colleagues) but no detail was known.

7.5 As a result of the limited information of friends or family and Sarah feeling she was unable to take part within the review the chair was unable to speak or gather further information to support the review.

8. Contributors to the review

8.1 As a result of the initial scoping exercise carried out by Safer Somerset Partnership the panel identified agencies to complete a chronology of contact and an IMR.

8.2 This report has been compiled from this information and facts from:

- Reports and presentations from;
    - Avon and Somerset Constabulary
    - Hampshire Constabulary
    - Hampshire Children Social Care
    - Somerset ICS
    - Somerset Education – Primary School and Independent School
    - Somerset NHSFT
- Discussions from the Review Panel meetings

8.3 Each agency was provided with copies of the IMR's and given the opportunity to provide feedback of each report. This quality assurance process ensured high quality outcomes for each IMR, and the panel was satisfied that the process reached expectations.

8.4 The panel consisted of statutory partners as well as those who were identified to have expertise and were able to add value in the discussion and the report. A Suicide Prevention specialist was no present at the panel, however, to support the review the Health Improvement Manager for Public Health (lead for Suicide Prevention) was consulted with and supported the analysis, learning and recommendations. All panel members were required to review each IMR, provide feedback at panel meetings and support the process.

8.5 The review panel consisted of:

Name and Job Title	**Agency**
Katie Bielec - Independent Chair and Report Author	Bielec Consultancy Limited
Suzanne Harris - Senior Commissioning Officer	Somerset Council
Su Parker - A/Detective Inspector	Avon and Somerset Constabulary
Emma Read - Designated Nurse Adult Safeguarding	Somerset Clinical Commissioning Group
Heather Sparks - Named Professional for Safeguarding Adults	Somerset NHSFT
Mark Brooks - Chair of Trustees	Mankind Initiative
Kelly Brewer - Team Manager	Somerset Children Social Care
Claire Chantler - Executive Head Teacher	Beckington School
Sally Cox - Head Teacher	Springmead School
Steve Kensington - Area Manager West	The You Trust - SIDAS
Jane Harvey-Hill – Team Manager	Inclusion – SDAS

*Education Safeguarding were invited to attend the panel members but did not attend.

9. Author of the Overview Report

9.1 Katie Bielec was appointed the Independent Chair and author for the review. Katie is an independent domestic abuse consultant providing support and training to councils and businesses across England and chairs MARAC, chaired Multi Agency Risk Management Meetings, and stalking clinics. She is an associate trainer for Safelives, Rockpool, The Hampton Trust, a guest lecturer for Bournemouth University and is an accredited trainer delivering Coercive Controlling Behaviour and Stalking Awareness.

9.2 Katie was previously a Metropolitan police officer for 5 years working in a variety of roles and is a qualified IDVA, IDVA manager, Independent Sexual Violence Advocate (ISVA) Manager and has managed domestic abuse services across the southwest between 2010 and 2021 with The You Trust. Although the You Trust are panel members and were the provider of the domestic abuse service within Somerset (SIDAS) at the time of Adam's death, however they were not involved with either Adam or Sarah. Katie was not connected with this project and was the manager of the Dorset Domestic Abuse Service. Since leaving the You Trust Katie has worked independently from trust.

9.3 Katie has completed the Home Office Domestic Homicide Review Training, is an accredited chair with AAFDA and SILP[5], a member for AAFDA DHR Network, Standing Together Against Domestic Abuse Coordinated Community Response (CCR) and The Employers Initiative on Domestic Abuse (EIDA)

[5] https://www.reviewconsulting.co.uk/

9.4 Katie is not associated in any way to any agency who have provided information for the review or had any personal or professional involvement with Adam or the family.

10. Parallel Reviews

10.1 The Inquest was held in November 2021, based on the evidence available, Adam's death was concluded to be as a result of suicide.

10.2 There were no other reviews being conducted at the time of this review.

11. Equality and Diversity

11.1 The chair and panel members considered whether the protected characteristics of:

- Age
- Disability,
- Gender reassignment,
- Marriage and Civil Partnership,
- Pregnancy and maternity,
- Race
- Religion and belief,
- Sex
- Sexual orientation,

were relevant in this review.

11.2 Adam was a 45-year-old and Sarah was 47 years old at the time of his death

11.3 There is no information to suggest Adam or Sarah had a disability. It is noted that Adam had depression and anxiety however, this was not diagnosed as a disability. It has though been explored within the discussions with mental health services included on the panel.

11.4 Adam and Sarah remained legally married however they had separated, the risk to those subjected to domestic abuse escalates when a relationship ends. Therefore, the panel explored the risks and impact this had on Adam and Sarah when their marriage ended.

11.5 Gender reassignment was identified as not relevant for the review.

11.6 Sarah had her first child in 2012 however sadly experienced post-natal depression after the trauma of a still birth in 2014. They subsequently went on to have a second child in 2015. There was no indication of any pregnancy or maternity issues at the time of Adam's death.

11.7 Adam was and Sarah and their two children are all white British.

11.8 There is no reason to believe that any party had a religious belief.

11.9 Adam's sex was taken into consideration for this DHR as a risk factor due to domestic abuse of men being significantly fewer than female victims. Mankind found in 21/22[6] that:

- 66% of the men who call the ManKind Initiative helpline have never spoken to anyone before about the abuse they are suffering and 64% would not have called if the helpline were not anonymous.

[6] https://mankind.org.uk/statistics/statistics-on-male-victims-of-domestic-abuse/

- Half of male victims (49%) fail to tell anyone they are a victim of domestic abuse and are two and a half times less likely to tell anyone than female victims (19%).
- 11% of male victims (7.2% women) have considered taking their life due to partner abuse. The charity has seen an increase in calls regarding suicide ideation over the pandemic period and beyond.

Therefore, the panel felt it important to understand the barriers Adam faced in identifying the abuse and seeking support as well as agencies responses.

11.10 Adam was believed to be heterosexual as was Sarah.

12. Dissemination

12.1 Once notification has been received from the Home Office that the draft report has been agreed panel members (Section 9), the Independent Chair, Safer Somerset Partnership and Avon and Somerset Police Crime Commissioner will receive copies. The family will be informed of the date of publication and where the review will be distributed.

13. Background to the suicide – The Facts

13.1 Police records indicate Adam and Sarah were in a relationship for 10 years and were married in 2014. There have been calls to police during the relationship by both parties.

13.2 The couple separated in 2020 and divorce proceedings commenced 3 months before Adam's death.

13.3 According to the Police, on the night of Adam's death Sarah had informed him that she had started a relationship with a family friend. After receiving this news Adam called Sarah's new partner and had a calm conversation with him for about 15-20 minutes.

13.4 Adam left the family home early that evening. He allegedly went to a neighbour's house and drank alcohol. When he returned home later that evening, he handed Sarah a letter wanting to talk to her, but she refused (the detail of the letter was unavailable for the review).

13.5 Adam went to one of his children's bedrooms (this was apparently where he usually slept at the time). Their child was sleeping in the same room as Sarah due to their bed being covered with Adam's work clothes.

13.6 The next morning Sarah found Adam had taken his own life. She called her boyfriend and a neighbour, who then called an ambulance.

13.7 The coroner in November 2021 concluded that in June 2021 at his home address in Somerset, Adam deliberately suspended himself by the neck with the intention of ending his life.

14. Overview/Chronology[7]

14.1 In early February 2017 whilst residing in Hampshire, Sarah called Hampshire Police after being pushed by Adam, she also disclosed to officers he had strangled her in the past. Adam was arrested, in interview he admitted the pushing incident, but denied any strangulation. He was

[7] Details of the relationship between Adam and Sarah has been difficult to ascertain as there has been no communication with family or friends, therefore, the review has been dependent solely on the reports provided by agencies.

charged and bailed. A DASH was completed, and Sarah was identified as high risk from Adam and was referred to MARAC.

14.2 The Police made a referral for Sarah to the National Centre for Domestic Violence (NCDV) and for IDVA support as well as providing safety planning. (Target hardening and refuge was offered and declined as Sarah told officers she was not in fear for her safety).

14.3 A Child and Young Person Report (CYPR) was completed in line with FPP 01911 (process to identify and share with relevant partners details of any child at risk due to being present or linked to a domestic abuse incident) as the children were present at the time of the incident.

14.4 Children Social Care (CSC) received a notification 2 days after the Police were called by Sarah. Information provided indicated Adam had grabbed Sarah causing cuts to her arms. CSC report states the parents had argued after not being able to go out for the evening which was fuelled by alcohol. Sarah called the Police after Adam had grabbed her by the arms causing marks. Sarah disclosed previous and frequent domestic abuse. The social worker spoke to both parents and report Sarah was being protective of the children and herself. There was no role identified and the case was closed. The social worker did not complete a DASH RIC with Sarah. They had not been informed the case had been referred to MARAC and therefore did not identify the case as high risk.

14.5 The MARAC was held several days after the incident. Present were: Police, You Trust (commissioned IDVA service), Community Rehabilitation Company (this is now back under the National Probation Service), Health Visiting Service provided by Southern Health Foundation Trust, the local hospital, Inclusion (substance misuse), Adult services and Hampshire Fire and Rescue. CSC and Education were not present. The IDVA noted Sarah had stated the incident was a one off and the couple were working through it. The only action recorded was for the Health Visitor to liaise with the GP, it is unclear if this was ever completed.

14.6 Following the MARAC, the police made a further referral to CSC (no date provided) with concerns that Sarah was staying with Adam in a hotel as his bail conditions would not allow him home. They were concerned Sarah was minimising the concerns and placing the children at risk of emotional harm. They also raised concerns that Adam was reportedly drinking alcohol again and Sarah no longer wanted to pursue the complaint. The social worker completed their assessment, carried out agency checks and assessed that Sarah was not minimising the incident. It is unclear how this was determined as no DASH was carried out and no further information was available.

14.7 Sarah provided a statement to the Police stating she did not want to pursue her complaint and as a result Adam received a conditional caution at court. PNC and PND were updated with regards to the domestic assault however, Adam's date of birth was entered incorrectly and there was no record the case was heard at MARAC, which was identified within the IMR as human error.

14.8 In June 2017 Adam and Sarah attend the GP together. Adam raised concerns regarding his misuse of alcohol and the notes indicate that both parties were supportive of each other. A referral was made for an Inclusion Recovery Centre (a service providing advice, information, harm reduction interventions and recovery planning for those with drug and alcohol addictions in the local area) It is unknown if Adam engaged with this service.

14.9 The family moved to Somerset in January 2018.

14.10 The eldest child was enrolled into their new school at the end of January 2018. Sarah informed the school there had been domestic abuse when living in Hampshire and the family had moved to Somerset to start a new life.

14.11 The school received information from Hampshire Children Social Care informing them of their assessment where domestic abuse was noted. Included was the Police DASH RIC (score of 9 – Medium risk), however, the MARAC was not recorded within these documents.

14.12 In March 2018 Sarah was seen by the health visitor for an initial 'transfer in contact' (e.g., when someone new moves to area). This was the only time she was seen by the health visiting team. The health visitor obtained information from GP records noting that Sarah had been a victim of domestic abuse in 2017 and added an alert on the system[8].

14.13 In June 2018 Adam was invited to the GP for a review for hypertension. He recognised he was smoking and drinking heavier than the healthy amount. The GP had a detailed conversation with Adam, provided details of Smoke Free Somerset and they both agreed that he would try a healthier lifestyle for 2 months.

14.14 In September 2019 Adam informed the GP he felt better, he had not drunk alcohol for 6 weeks. The conversation appeared to be positive and comfortable, there was no indication of domestic abuse with Adam telling the GP they were both happy and Sarah was well.

14.15 During February 2020, the youngest child was heard at school saying "*I am going to cut your throat open*" to another pupil and the child told the teacher this was how he always played. He was reminded to use kind words and at no point was a parent spoken to about these concerns. The school noted Sarah had always said their youngest child had 'anger issues'.

14.16 Shortly after this there was a global pandemic, and the UK experienced its first lockdown from 23/3/2020 – 10/5/2020. Schools were closed during this time (unless a parent was a key worker, or the child was identified as vulnerable). Both children stayed at home and were home schooled. The school kept in weekly contact with families and no concerns were raised.

14.17 Shortly after returning to school in June 2020 the youngest child drew a picture on his emotions board of a scared face. When asked about the picture the child told staff "*I'm scared of my Daddy, he shouts at Mummy, so I'm scared*". The teacher raised this with the schools Designated Safeguarding Lead and a decision was made to monitor the situation. No parent was spoken to regarding the incident.

14.18 Ten days later the school spoke with Sarah to discuss why the children were not in attendance. Sarah explained they were with family in Wales as the situation at home and her relationship with Adam had deteriorated especially since lockdown. She described how the arguments and shouting had gotten worse and that Adam was drinking more alcohol. Sarah told them she had asked Adam to leave but he had refused as his mother was living with them who had terminal cancer[9]. Sarah was concerned she could not afford a divorce and was only coming back because of the children.

14.19 In September 2020, the eldest child did not return to his primary school and was placed in the local independent school where he settled well into Year 4 and had a normal term. The original

[8] At that time Health Visitors were under Somerset Partnership NHSFT (now known as Somerset NHSFT), however, they are now under the local authority.
[9] It is unclear when Adam's mother passed away due to terminal cancer, but it is believed to have been approximately 18 months prior to his death, we can only imagine the impact this would have had on the whole family.

primary school reported that they were shocked by the move as Sarah had been adamant both children would remain with them, and the family did not have the funds to pay for the new school.

14.20 The nation went into a second lockdown on 11/11/2020.

14.21 Two weeks after the second lockdown began Sarah contacted the Police to report she was concerned for Adam's welfare. She explained one of his friends had informed her that he had tried to take his own life a few weeks earlier. During the conversation Sarah informed the call handler she was frightened of Adam especially if he came back. Sarah asked for her property to be flagged.

14.22 The Police recorded Adam as a MISPER and then located him with a friend. He informed them things were not very good at home, but he was safe and well.

14.23 Sarah was spoken to after the Police had located Adam. She described the home as unhappy and unhealthy. It does not appear that officers asked her about domestic abuse and/or were unaware of the concerns she had raised about being frightened during the initial call. An internal referral was made to the LSU.

14.24 The day after the Police had been called regarding the MISPER, Adam spoke with his GP stating lockdown had played havoc with his mental health and left him feeling very sad and anxious at times. He disclosed he had a low appetite, sleep disturbance and that he had had to furlough himself as he is self-employed. Adam explained his marriage was 'on the rocks' and that he was staying with friends who were being very supportive. He also mentioned he had commenced counselling sessions and had a second appointment later that week. Sertraline medication was prescribed for his anxiety and depression as he felt they had helped him previously. The GP noted that Adam shared he had occasional thoughts of not wanting to be alive but reiterated that his friends were very supportive.

14.25 Early in December 2020 the primary school noted when the youngest child arrived at school looking sad. A teacher commented, "*There's only 11 more school days until Christmas*." Sarah replied, "*You might be looking forward to Christmas but I'm not. I do not want my children home for that long*." After this conversation, the teacher raised concerns for the child's well-being as he was often sad, withdrawn and finding life hard. Sarah was spoken too, to see if she was ok. She described being tired and home life being awful due to the impending divorce and that Adam had been back to the house the night before for the first time in a long time.

14.26 In a 'playground gate conversation' at the older child's school, Sarah told a senior member of staff things were difficult at home and had been for a long time. She was asked how they could support her, and she asked them to keep an eye on the child. The teacher and teaching assistant were informed of this conversation however they did not notice a change in his behaviour during this time.

14.27 Two weeks later the Police received a call from Sarah reporting Adam being verbally and emotionally abusive towards her. She claimed he had called her over 20 times in an hour whilst she was out, shouting and wanting to know when she would be back. Sarah also reported that he had told their children that she had left them and was getting them to leave messages. He had since left to stay with a friend. As a result of the conversation and the THRIVE assessment, the call was upgraded from Routine to Priority attendance. Units were

advised to check in advance of attendance that he was not home. No units were available to attend due to operational demand.

14.28 36 hours later an officer spoke with Sarah via telephone. Sarah explained Adam's behaviour had become difficult since she told him she wanted to end their marriage. He was drinking excessively and had become controlling asking where she was and why she was going out, believing she had met someone else. Sarah did not want to make a formal complaint and Adam was not spoken to because of this conversation.

14.29 The officer recorded this incident as no offences identified. A DASH was completed as standard risk, and a BRAG was completed with a result of green. NCDV information was provided, a notification was sent to the LSU and education safeguarding. The LSU did not contact Sarah after receiving the referral, there is no reason recorded for this decision.

14.30 Four days after Sarah called police, Adam attended a local police station to report that Sarah had threatened she would make false allegations to get him arrested if he did not pay her more money. Adam wanted this information logged in case Sarah called police and did not want to make any further complaints.

14.31 An officer called the same day to clarify details. Adam stated Sarah was a good mother, respected her decision (to start divorce proceedings) and wanted the separation to be amicable and completed asap. The officer recommended legal advice so child access/support could be organised. A DASH was completed as standard, Adam was offered support which he declined. An internal referral was made to LSU who made 2 attempts to make contact and the allegation was classified as blackmail. A notification was sent to education safeguarding and health in respect of the children.

14.32 Just before Christmas 2020 the eldest child's school received the police notification regarding Sarah. They contacted her offering support, and she informed them things had settled down. They told Sarah they would be keeping an eye on her child upon their return to school in the New Year. No call was made to Adam by either school to offer the same support.

14.33 Neither child returned to school after the Christmas break, as the nation went into the 3rd lockdown on 6/1/2021. The eldest child's school offered them a place during this time, but it was declined.

14.34 There was a staged exit of lockdown with different easing restrictions dated 8/3/2021, 12/4/2021 and 17/5/2021.

14.35 Mid-May 2021 Adam called 999 from the home landline following an argument with Sarah. He reported Sarah had taken his phone and smashed it into the ground. Adam made allegations that Sarah used cocaine whilst caring for the children and had caused bruising to her own body falsely alleging, he had been violent towards her. He also reported threats and verbal abuse by Sarah and her parents. The call was graded priority and tasked for attendance. He informed police he would not be available that evening but was keen to speak to them as he was concerned Sarah would make allegations against him.

14.36 Due to service demands Adam was not seen immediately, however there were several calls between Adam and the Police. He told them he was unavailable to meet with officers due to having the children. The officer advised Adam to consider his and his children's safety and to leave the property if they were at risk. Adam reported he was not at risk of physical harm, and he was suffering emotional abuse. He agreed to meet a police officer at a police station at the

end of May, he did not attend the appointment. A final attempt to call Adam was made on 1/6/2021 but there was no further contact from him.

14.37 A couple of weeks after Adam's contact with the police, Sarah informed him of her new relationship, and it was later that evening he took his own life.

15. Analysis

15.1 Throughout this process via the IMRs, meetings with schools and discussions at the panel, indications are that Adam and Sarah may both have been victims of domestic abuse. Therefore, throughout the review the panel agreed to consider and analyse the response of agencies to both Adam and Sarah.

15.2 Hampshire constabulary

15.2.1 In 2017 when Adam was arrested in Hampshire for assaulting Sarah, he admitted the event immediately. The police recognised the risks and showed concern that Sarah appeared to be minimising the abuse and raised these concerns with children social care. Hampshire Police should be recognised in their positive response to these allegations and how they supported Sarah.

15.2.2 The DASH completed had good use of the free text boxes and identification of a further offence that had occurred in 2015 when Adam had grabbed Sarah by the throat causing significant reddening. Although this was not reported to the police at the time Sarah had retained a photo and they recognised this as a high-risk factor. There were further disclosures from Sarah including when Adam once slapped her hard around the face in front of their child. It was recorded that Sarah felt afraid of further violence. There appeared to be a good understanding by the attending officers of the importance of asking open questions when completing the DASH to ensure maximum opportunity to gather information supporting professional judgement and assessing risk.

15.2.3 During this time Sarah fluctuated from being fearful of Adam to not, as well as making allegations of violence and then minimising them. This is not unusual with those who are subjected to domestic abuse as they will continually risk assess their situation and safety plan from day to day.

15.2.4 Hampshire Police acknowledge a missed opportunity with regards to the safeguarding of the children at the time of the assault. Although a Child and Young Person Report (CYPR) was completed the officer records that they checked the children and identified no concerns. However, within the CYPR the voice of the child is not apparent with no description of what the children said and how they had presented.

15.2.5 In the statement provided by Sarah she stated her 4-year-old had said to her '*Can we leave Daddy, he frightens me*'. She also described how she had asked Adam to stop shouting when her youngest child was present. Furthermore, the CYPR did not emphasise that based on Sarah's disclosures there appeared to be an emerging pattern of coercive, controlling, and violent behaviour which had occurred in front of the children.

15.2.6 Since 2017 Hampshire Constabulary has developed the Child Centred Policing Strategy which places a much greater emphasis on the voice of the child and a trauma informed approach to children. Further to this, significant training was mandated across the force in 2018 named 'Domestic Abuse Matters' and run by SafeLives. Progress was monitored independently by

SafeLives in terms of a 'health check' approximately 1 year after the training. This training is now recommended and an action within the Tackling Domestic Abuse Plan 2022[10] for all Police forces to undertake.

15.2.7 Hampshire Constabulary also has a large network of DA champions who cascade training and learning. This has included regular input with regards to the voice of the child at a domestic incident.

15.2.8 Since this time Hampshire Constabulary remains in touch with the evolving research and understanding of the dynamics to domestic abuse. There is a current Domestic Abuse Strategy and Tactical Action Plan with oversight from a gold and silver command structure. This is combined with ongoing training coordinated by a Domestic Abuse Specialist Inspector via an extensive network of domestic abuse champions throughout the force. Their role is to disseminate learning and training that is garnered via national research and via local review and scrutiny mechanisms. This includes a Domestic Abuse Scrutiny Panel and monthly themed champion reviews using a large dip sample of live cases. Any learning from these audits' feed into the central Organisational Learning team.

15.2.9 The safeguarding team has since restructured, most of the safeguarding and planning is now conducted by commissioned services and the OIC are included in the investigation. This is supported in the investigations command by the Domestic Abuse Support Teams (DAST) who since July 2020 support investigators in undertaking proactive work with victims and increasing the number of formal outcomes.

15.2.10 Due to the passage of time and the change in practice no further recommendation will be made regarding Hampshire Constabulary's response to the voice of the child. Police were proactive in completing the DASH and made the appropriate referrals to MARAC, IDVA and children social care.

15.2.11 The MARAC identified concerns that Sarah had been minimising the domestic abuse and had stated it was a one-off incident which was different to her original account. There was a lack of engagement with the IDVA, and it is not clear if there was any exploration in how to promote engagement with the service.

15.2.12 CSC and Education not being informed of the MARAC was a missed opportunity to share information, understand the risk to Sarah and the family and support the IDVA engagement.

15.3 Hampshire Children Social Care

15.3.1 CSC carried out their Section 47 Assessment without vital information of the high-risk concerns regarding domestic abuse. This was a missed opportunity to speak with Sarah and the children about the situation at home and the domestic abuse and to then be able to evaluate the risk with all the information available.

15.3.2 Without this information, it is unclear how the social worker determined that Sarah was not minimising the abuse or risk the family may have been at, when the police referred the family a second time. No DASH was completed to support this. If a DASH had been completed, and the social worker had been involved in the MARAC, it raises the questions as to if the outcome of the assessment would have been different. It is of course impossible to answer this, but it

[10] https://www.gov.uk/government/publications/tackling-domestic-abuse-plan

does highlight that when there is a gap in sharing of information and the risk assessments are not being used, it can impact on the decisions being made by practitioners and the support options provided to those subjected to domestic abuse.

15.3.3 Hampshire safeguarding processes have changed since 2017 and the current process is now:

- Cases identified as High Risk are now heard at HRDA within the MASH, this enables a multi-agency assessment of risk and is undertaken within 24 hours of a high-risk domestic abuse occurrence. This was created due to the gap in time between incident and MARAC and the sheer number of cases being heard at any one time. The HRDA is a timely and effective way to address risk and expedite required actions. Additionally, due to the meetings being in the MASH all appropriate agencies are present. Cases which are complex are then referred for the monthly MARAC.
- There is now a dedicated team of social workers who attend the HRDAs and MARACs with the responsibilities to share relevant information, suggest and take actions and update records therefore families will not be missed as with this case.

15.3.4 With the changes already made there are no recommendations or learning for Hampshire Child Social Care.

15.4 Hampshire Primary Care (General Practice)

15.4.1 When Adam and Sarah spoke with the GP in June 2017 there appeared to be a robust consultation with regards to Adam's misuse of alcohol. They appeared to be making steps to address his alcohol use together. There does not appear to be any follow up by the GP of the referral to the Inclusion Recovery Centre with regards to whether he engaged. This was a missed opportunity to continue to support and monitor Adam's use of alcohol, his health and wellbeing. However, due to the length of time since this referral was made no recommendation will be made.

15.5 Somerset Education

15.5.1 When Sarah disclosed to the new school in Somerset there had been domestic abuse whilst in Hampshire no further information was sought or questions asked by the school staff to either support Sarah and the children or to find out what intervention had been provided. Sarah making this disclosure was an opportunity for support to be offered in Somerset and to make any safeguarding enquiries.

15.5.2 When the 4-year-old child used a violent comment in the correct context it would have been best practice to for staff to have raised concerns by school staff and this should have been explored further. There were no discussions with either parent and no concerns were raised for further investigation. This was a missed opportunity to discover where the child had heard this type of violence/language, and this would support any intervention required.

15.5.3 This same child also drew a picture telling staff he was scared of Daddy when he shouts at Mummy. This was possibly the child reaching out to staff with regards to their concerns at home. The Domestic Abuse Act 2021[11] introduced into legislation children as victims of domestic abuse and no longer witnesses. Any concerns for a child where there may be domestic abuse within the home should spark further exploration by those working with them.

[11] https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted

15.5.4 When the eldest child told staff at (his first) school that he used to jump on their Daddy's back when he was giving Mummy one, they never explored what this meant or investigated further with Sarah. This comment gives an indication the children were witnessing Adam being violent to Sarah. Without further discussion with the child and/or Sarah, associating the possible risks after the previous disclosures of abuse and the observed behaviours, the school missed the opportunity to probe into the dynamics at home, appropriately risk assess and make any relevant referrals.

15.5.5 The absence of professional curiosity and awareness of domestic abuse was also evident when the school spoke with Sarah in July 2020 whilst she was in Wales with the children. Even though there were no direct disclosures of domestic abuse there does not appear to have been the evaluation of risk to Sarah or the children upon their return. There were also the additional risks of isolation especially for the children as the summer holidays were to start imminently, therefore taking them away from their possible safe place. Sarah was not offered or signposted for support for domestic abuse, financial support or for Adam's drinking. It is a positive that Sarah felt able to speak with the school and it is a missed opportunity that this openness was not utilised. Furthermore, no contact was made with Adam to offer him support at any stage after these concerns were raised. Sarah seems to be the primary contact for the school rather than both parents.

15.5.6 In December 2020, a teacher takes positive steps to raise concerns for the youngest child's well-being as he was often sad, withdrawn and finding life hard. Although Sarah was spoken to after this concern it does not appear that staff identified what was happening within the home. An added complexity for the school to 'join the dots' may have been due to the children being in different 'years' and concerns and disclosures were not being connected to create a bigger picture. It would be beneficial for schools to understand non-verbal indications of abuse for children and victims and have robust processes to share information across all year groups ensuring safeguarding those who are vulnerable to abuse.

15.5.7 There was a further opportunity for the independent school to assess the situation with Sarah after receiving the police report and after she disclosed things were difficult at home and had been for a long time, Sarah asking the school to keep an eye on the child is positive as she is recognising the possible impact on them. Adam was not spoken to and only Sarah was offered support and someone to speak to. It is not clear why this was or if any attempts were made to speak with Adam.

15.5.8 From the disclosures by the children and Sarah it appears Adam may have been using coercive and controlling behaviours, possibly using violence and there was fear within the home. Both schools were having regular informal conversations with Sarah but at no stage was domestic abuse disclosed or considered. She reassured them she was caring for the children, and it was felt the family did not meet the criteria for an Early Help Assessment referral. Additionally, the incidents appear to have been dealt with in isolation rather than building a picture of what was happening within the family.

15.5.9 Due to domestic abuse not being identified by either school a DASH was not considered or completed with a failure to 'join up the dots' of previous domestic abuse, disclosures of physical abuse, fear from the children and the concerns raised by Sarah it meant there were missed opportunities to offer support to the children and Sarah. Furthermore, there were multiple missed opportunities within education to refer to children's social care based on disclosures made by the children's drawings, behaviours, and demeanour.

15.6 Avon and Somerset Police

15.6.1 When Sarah called the Police in mid-November regarding her concerns for Adam's welfare (Sarah had been informed of a previous suicide attempt by friends however there is no known or reported suicide attempt on any formal agency records), she stated she was frightened of Adam coming home and asked for her home to be flagged. The call was marked as a MISPER which was correct, and the call handler noted Sarah's fear however, this was a missed opportunity to explore further with Sarah why she was frightened.

15.6.2 When there is a disclosure of fear from a partner or ex-partner there does not appear to be a clear process how the call handler records this. It is not routine for call handlers to complete the DASH which is understandable due to the volume of calls at any one time. However, it is to be recognised that when a victim of abuse calls Police and makes a disclosure this is an opportune time to seek further information to be able to assess risk and signpost to specialist services.

15.6.3 From the call, the call handler identified Adam as a priority MISPER with the Police responding immediately using appropriate resources and tools to locate him.

15.6.4 Due to Sarah describing him as vulnerable it would have been appropriate for officers to complete a BRAG during their contact with him. However, the Police believe it would have been unlikely the BRAG would have generated any additional referrals.

15.6.5 Adam explained to the officer's financial difficulties, struggles with the recent death of his mother, and wanted time to himself with no intention to harm himself. Officers do not appear to have explored the dynamics of the family life especially after Sarah had made comments of being frightened of him. This may have been an opportunity for Adam to disclose domestic abuse. It is not recorded and therefore not known if officers discussed Adam's mental health, therefore signposting him to support services or his GP during their interaction which would have been expected with these cases.

15.6.6 Since Adam's death there is a new initiative which has placed Mental Health Link Officers with triage nurses in the triage hub. These officers are specially trained police communications staff who monitor incoming calls related to welfare, suicide, and missing persons as they arrive and enable early and immediate mental health triage involvement and advice for these incidents.

15.6.7 There is currently no effective agreed way of sharing mental health information by police to GP or to secondary mental health services. A referral to mental health services can take place via the GP, an individual can self-refer to Talking Therapies, access support via Open Mental Health, Police can contact the local MH duty team number or home treatment team numbers for advice/support, or the police mental health triage team. Not all mental health conditions require referrals into secondary mental health services (CMHS) and this seems to be a common misconception. This concern has already been highlighted within a previous domestic homicide review and is being explored by the OPCC and ICS (previously CCG) to identify any future ways of working.

15.6.8 When officers met with Sarah after speaking with Adam, she described an unhappy home environment, but that Adam was hopeful the marriage would continue. It is not clear if the officers were aware of her fear of Adam and therefore were unable to explore this further with her. Officers would have been able to view the STORM call log prior to attending the call via their laptops or phones (often officers have limited time between jobs to be able to read detailed information), they are given relevant information by the dispatchers when

responding to an incident. It is not known what information dispatchers gave the officers when responding to this incident.

15.6.9 26 days after the MISPER call where Sarah had stated she was frightened of Adam, Sarah called 101 to explain the difficulties of the situation, describing Adam's behaviour as emotional and manipulative. She disclosed over 20 calls in an hour, and he had told the children she had left them and was making them leave her messages. Lundy Bancroft[12] states in his research that domestic abusers will use children as a weapon to control and emotionally abuse their victims, which may have been the case here.

15.6.10 The call handler advised Sarah that the call was priority graded and would be contacted in the next few days (that it would not be that night and the following day could not be guaranteed as it would depend on how busy it was particularly as the weekend was starting). Sarah was asked to call back if there were any further incidents, she was happy with the timeframe for attendance and did not express any dissatisfaction.

15.6.11 Police carried out a PNC check and it returned as no match for Adam, so the police had no knowledge of the previous alleged assault in 2017. It has since been identified that his date of birth on PNC is incorrectly recorded and this provides an explanation why there was no match.

15.6.12 Communications (control room) staff assess an incident according to the THRIVE (Threat, Harm, Risk, Investigation, Vulnerability, Engagement) matrix based on the information available throughout an incident. This THR assessment is dynamic and can change as an incident progresses. Incidents are resourced based on the THR level and operational demands on the service at the time of the call/incident. At the time of Sarah's call, there was no formal recording of THR for a call and the assessment was based on the call handler's professional judgement.

15.6.13 Since October 2022, there has been an implementation of a new process to assess the THR and provide more structure to THRIVE assessments within the control room. A THRIVE form is now completed for each call card (excluding immediate graded incidents) at the time of the call. The THRIVE is then reassessed as part of the 48-hour review if a call response it remains outstanding.

15.6.14 A dispatch supervisory review at 23:51 hours agreed with the Priority grading. At 23:58 the dispatcher acknowledged the log but noted that all units were committed, and the call would be resourced in line with THRIVE.

15.6.15 The following day at 16:22 hours, the call was still awaiting dispatch and it was noted that there had been limited officers in the area that day, so the call had been unable to be resourced.

15.6.16 36 hours after Sarah's call, the dispatcher provided a summary of Sarah's complaint and allocated a unit to attend. In line with the requirement to call in advance, an officer called Sarah at 10:51 hours but did not get an answer and left a message. A follow up text was sent at 13:15 requesting Sarah call 101, an officer then spoke to her around 14:00 hours.

15.6.17 It is concerning a victim that has called the police and is alleging they are experiencing harassment, has had threats made against her, had previously stated she was frightened of her husband, was experiencing possible coercive and controlling behaviours, had made steps to contact the police and was marked as a priority call, then had to wait 36 hours to be

[12] https://lundybancroft.com/

contacted. Although we are unable to know the impact of this on Sarah, the possible impact may have resulted in her feeling not heard and possibly not believed. Additionally, this period may have also enabled Adam to minimize, deny or blame Sarah for the behaviour, questioning her sense of fear and concern. Taking this into account and how Sarah presented when police later spoke with her may explain why she changed her narrative. These concerns have been acknowledged by the police.

15.6.18 Due to the THR and operational demands of other calls, officers were unable to respond to the call until 36 hours later when an officer called and left a message. The Police acknowledge response time for Sarah's call was outside of expected targets and there are calls that cannot be responded to within target times. Attendance to calls is frequently impacted by operational and THR demands. Capacity is managed through the Capacity and Demand Plan – a force wide plan identifying tactical options that can be taken to increase capacity and reduce demand when responding to spontaneous changes in demand and resource levels. Tactical options include cancelling planned training, using other units (such as neighbour and Operation Remedy to respond to calls). The Capacity and Demand plan is triggered by review of the Demand Status level, identified in part by the number of calls outside of SLA response times (>300 calls)

15.6.19 When the officer called Sarah, she explained that Adam's behaviour had become difficult since she told him she wanted to end their marriage; he was drinking excessively and had become controlling asking where she was and why she was going out, thinking she had met someone. She did not want Adam arrested but wanted advice on how to obtain an injunction. Sarah was signposted to National Centre for Domestic Violence for an injunction. A DASH was completed scoring Standard and a BRAG resulting in Green. Sarah requested support for an injunction but there is no evidence she was signposted to Somerset Integrated Domestic Abuse Service (SIDAS) or another support agency. This is a missed opportunity for Sarah to have been able to access local advice and support for herself and the children.

15.6.20 IAU classified the crime as stalking due to HOCR guidance that harassment between ex partners must be recorded as stalking unless FCIR (Force Crime Independent Registrar) is satisfied it is harassment only. The crime recording classification for this incident was not requested to be changed by the officer and was not amended.

15.6.21 Although this case was classified as stalking the officer who spoke with Sarah assessed there were no offences and required no further investigation. It is possible that she minimised incidents when speaking to officers or they seemed less significant to her in hindsight. The SDASH is incorporated with the forces DASH, when asked Sarah responded '*No*' to question 8 *'Does [name of abuser(s)] constantly text, call, contact, follow, stalk or harass you?*', therefore the additional 6 questions relating to stalking were not asked.

15.6.22 The case was submitted to a supervisor (Sergeant) for review prior to filing. He agreed that there were no offences to investigate as the behaviour was unreasonable but did not require further police action unless there was further escalation.

15.6.23 It is known that victims contacting the police can find this to be scary, but the officer had a detailed conversation with Sarah, and it is possible that the way Sarah presented over the phone had given the officer the perception there was no abuse or risk. With the information provided by Sarah at the time they responded appropriately providing NCDV information. However, the officer could have explored in more detail Sarah's disclosure of controlling behaviour to identify any behavioural patterns and the concrete examples requiring further

investigation. Understanding of the complexities of victims of domestic abuse and their response may have resulted in a different outcome[13]. Avon and Somerset Constabulary have previously identified the need to take steps to ensure officers can recognise coercive control more readily and take time to pursue further lines of enquiry when indicators of coercive control are disclosed or evident. Specific Controlling and Coercive Behaviour Guidance has been developed because of this recommendation and has been published. In addition, DA Matters training has now commenced and will be attended by all front-line police officers and relevant police staff.

15.6.24 A best practice investigative approach to the incident would have involved speaking to Adam, however this did not happen on this occasion. If the officer had made attempts to contact Adam, it would have provided an opportunity for Adam to share his experiences of domestic abuse and seek appropriate support.

15.6.25 The LSU not contacting Sarah may have been influenced by the determination that there were no offences to investigate. The unit's protocol is that contact should have been attempted in this case based on the classification made by IAU (IAU classified the record as a crime of stalking). Sarah should have been offered an enhanced service as a victim of domestic abuse in line with the Victim Code of Practice. Sarah had requested support; it may have been beneficial for the officer who spoke with Sarah to have provided local and national support numbers. There appears to have been an assumption that as a referral had been made to the LSU then follow up support would have been offered.

15.6.26 The Police responded in a positive way to Adam when he called in late December to report financial and emotional abuse from Sarah. Contact was made with him on the same day to discuss the allegation, a DASH was completed and an offer to meet him. Adam stated he was not fearful or at risk from Sarah, he alleged Sarah was acting unreasonably and aggressively (there is no further explanation of what this behaviour was), demanded more money and would report him to the police making up allegations to get him arrested. Adam wanted the threats to be logged in case Sarah called police with allegations. He alleged Sarah had told him to kill himself and that everyone would be better off without him. Adam also explained the family had financial concerns as Sarah was furloughed due to the pandemic, with all these concerns it had made his mental health issues worse.

15.6.27 There were four days in between calls and both Adam and Sarah indicated coercive and controlling behaviour plus other forms of abuse. The Respect Toolkit [14] explains that, although there are similar behaviours, male victims and female victims will experience these differently. It further explains how females who use abusive behaviours use weaponization of toxic masculinity[15] . Examples include – threatening to call the police and allege the male is the primary perpetrator or they will make false allegations. They may call him names, put him down and make him feel bad about himself, telling him he is crazy or mad, using the children against him and many more.

15.6.28 Elizabeth Bates (Bates, 2019) [16] found men experienced significant controlling behaviour (also labelled emotional or psychological abuse). In the sample, the men had reported experiences of gaslighting, manipulation (e.g., through children, use of false allegations, coercion around sex and pregnancy), isolation from friends and family, and experienced fear in their day to day

[13] https://safelives.org.uk/policy-evidence/about-domestic-abuse/how-long-do-people-live-domestic-abuse-and-when-do-they-get
[14] https://www.respect.uk.net/resources/19-respect-toolkit-for-work-with-male-victims-of-domestic-abuse
[15] Oxford Dictionary definition – A set of attitudes and ways of behaving stereotypically associated with or expected of men, regarded as having a negative impact on men and on society as a whole.
[16] http://insight.cumbria.ac.uk/id/eprint/4367/

lives of living with this abuse. These behaviours appear to mirror that of Sarah on Adam, the officer noted Adam did not make any criminal allegations, nor allegations of violence or threat of violence and did not consider himself as a victim. They were proactive in offering information to support Adam including advice to seek legal support and removing him and the children should they be at risk.

15.6.29 Respect (within the toolkit) states '*Men and boys are often led to believe that being depressed, feeling emotional pain, being bullied, feeling suicidal, experiencing eating disorders, being abused are "feminine" issues and that "real men" do not have them. This can leave men suppressing their pain, lacking the ability and security to talk about their emotions, and to lash out in what they perceive "acceptable" masculine ways, such as substance abuse and violence'.* Although we cannot be certain it is possible these societal barriers may have been a reason why Adam did not seek support from other professionals or continue with the allegations made to the police, alternatively he may have not identified himself as a victim of domestic abuse creating a further barrier in accessing support.

15.6.30 When the LSU carried out safeguarding background checks on PNC for Adam and Sarah there was no match and the incident deemed not meeting the threshold for Children Social Care, however, as per police process a notification was sent to Education Safeguarding and Health (in respect of the children). Adam was offered support but declined his details to be shared with agencies, however the LSU made 2 attempts to contact him. Both were unsuccessful.

15.6.31 Different responses were provided to Adam and Sarah by the Police and LSU. Officers called Adam the same day of his complaint whereas Sarah waited 36 hours. The LSU attempted to contact Adam twice, but they had not with Sarah. Additionally, although Sarah had disclosed harassment and possible coercive and controlling behaviour, no offences were recorded where they were with Adam even though he wanted no action to be taken. Although the LSU followed the correct process for Adam they did not for Sarah with no clear reason. There is no indication the response to Adam was due to him being male but that of operational demands. It highlights an inconsistency across the force in how officers respond to victims of domestic abuse.

15.6.32 Adam's disclosure indicated the abuse was impacting on his mental health, however, there does not appear to have been a discussion regarding support he was receiving, was required, or whether he was signposted to any mental health services.

15.6.33 When Adam called the police in May 2021, the information he provided indicated high risk factors present within the family such as:

- Violence within the home,
- Sarah's self-harm
- Drug use by Sarah when caring for the children,
- Allegations of coercion and control,
- End of the relationship
- Economic abuse

Police also had previous information that:

- Adam was at risk of suicide,
- The abuse was affecting his mental health.

15.6.34 The call was graded as a Top 5 priority (due to the presence of children and the other high-risk factors), it would therefore have been expected a welfare check to have been carried out on the children and any vulnerable person. This did not happen due to Adam informing

officers the children were going to be with him as he was collecting them from school. It raises concerns that a 999-call. graded as top priority, plus the high-risks Adam had disclosed, why the decision was made not to see the children and parents at the request of the victim. Although this decision may have been influenced by Adam, the police had a duty of care to ensure all those involved were safe and well.

15.6.35 This was a missed opportunity to gather the voice of the children to identify what was happening within the home and to see and speak with Adam (as well as Sarah) especially as there had been calls to police 6 months previously.

15.7 Primary Care (General Practice and Health Visiting)

15.7.1 It is unclear if the health visitor was aware of the domestic abuse prior to meeting Sarah in March 2018, it is not evident there was a conversation or disclosure of domestic abuse. It is positive that Sarah's records were flagged with regards to previous domestic abuse for any further reference.

15.7.2 There was limited engagement with the family in 2018, Adam's GP appointment in the June identified his unhealthy lifestyle and his want to change. The GP appeared to explore different options although it is unclear if Somerset Drug and Alcohol Service (SDAS) was discussed with him as this may have been an opportunity for him to access support regarding his misuse of alcohol. This would have enabled the GP to have explored Adam's home life and any contributing factors to his drinking and smoking however the GP did detail the conversations and no concerns were raised.

15.7.3 The day after the MISPER report in November 2020 Adam disclosed to his GP that lockdown had played havoc with his mental health highlighting some key concerning issues and impact. These include:

- Feeling very sad and anxious at times,
- Low appetite,
- Sleep disturbance
- Financial concerns due to furlough,
- His marriage was on the 'rocks',
- Staying with friends (instable housing),
- Had occasional thoughts of not wanting to be here.

15.7.4 It is positive Adam felt he was able to share these concerns with the GP as well as seeking additional counselling and having supportive friends. It may have been beneficial for the GP to have explored the underlying issues including his relationship and possible domestic abuse. For Adam, being male may have been a barrier for him to make a disclosure and the GP asking and/or recognising the signs may have helped although this cannot be for certain. it is important professionals can identify male victims, assess, and offer the appropriate support.

15.7.5 We do not know why Adam did not tell the GP of the police involvement the previous day, it may have been beneficial for the GP to have had this information to discuss risks, concerns and interventions as highlighted in learning point 4.

15.7.6 When Adam disclosed to his GP financial pressures due to furlough, the divorce, and seeking alternative accommodation in the future and the impact on his mental health and wellbeing, it is unclear what (if any) support or signposting was offered with regards to his financial concerns or the impact of COVID.

15.7.7 The British Medical Association (BMA) carried out research regarding the impact of COVID-19 and mental health[17], it found (and are relatable to Adam):

- *Social isolation may have a negative impact on mental wellbeing as stressors included frustration, boredom, financial loss and stigma. Normal positive coping strategies such as engaging in with support services, working, outdoor activities and seeing loved ones were harder to access. Evidence showed more unhealthy coping methods were resorted to such as increase in alcohol consumption.*
- *Living through a pandemic increased certain mental health conditions such as depression, anxiety and substance misuse and complex grief. Within the study is shared data from the 1918-19 flu pandemic in USA and the 2003 SARS pandemic in Hong Kong show an increase in suicide rates.*
- *The Economic downturn was a risk to mental health, evidence to suggested that increasing unemployment and financial hardship could see a rise in suicide rates.*

15.7.8 Another significant moment was the death of Adam's mother who had been living with him and the family until her passing. It is unclear what bereavement support Adam, or the rest of the family were offered or received. It may have been beneficial for the GP and school to have signposted or referred the family for bereavement support/counselling.

15.7.9 The Somerset Mental Health Alliance is an alliance of mental health organisations who have come together to provide 24/7 support to adults in Somerset via a freephone number, website, or email. The aim of the alliance is to ensure people living with mental health problems get the right support at the right time. Working together, they support people to live a full life, by enabling access to specialist mental health services, housing support, debt and employment advice, volunteering opportunities, peer support, community activities and physical exercise, to help support and improve their wellbeing and quality of life. The alliance uses a locality model at Open Mental Health to ensure individuals get the right care with their mental health. This means when an individual makes contact for support, they will be referred to one of the four locality hubs across Somerset. Within these hubs sits a team of professionals who together will discuss which Open Mental Health services are best placed to support a person on an individual basis.

15.8 Suicide and domestic abuse

15.8.1 It is evident during the last 18 months of Adam's life; he faced many difficult challenges. The loss of his mother, possible financial difficulties due to furlough, misuse of alcohol, depression and anxiety, alleged suicide attempts, living in between the family home and friends, the pandemic therefore possible isolation and being a victim of domestic abuse.

15.8.2 Adam appeared to resist Sarah ending the relationship and was likely to have been experiencing the grief of the loss of his marriage and a possible sense of loss of self-worth as a father and husband.

15.8.3 When all of these are taken into consideration, Adam was a vulnerable man at risk of harm to himself. Adam's experiences were also like those highlighted in the research from University of Manchester – NCISH 2021 – 'Suicide by middle aged men'[18]:

[17] https://www.bma.org.uk/what-we-do/population-health/supporting-peoples-mental-health/the-impact-of-covid-19-on-mental-health-in-england

[18] https://sites.manchester.ac.uk/ncish/reports/suicide-by-middle-aged-men/

- *Men aged 40-54 have the highest suicide rate in the UK, and account for a quarter of all suicide deaths.*
- *31% men reported recent relationship problems with their current or former partner; 20% had recently separated from their partner and 5% were going through the divorce process at the time of death and 10% of the sample they looked at were offenders of domestic/intimate partner violence and 7% reported being a victim of domestic/intimate partner violence.*
- *50% of the middle-aged men who had recently separated from their partner were living alone at the time of death. Those reporting recent relationship problems were more likely to also have recent financial problems, a history of alcohol misuse, expressed suicidal ideation or intent, and had service contact than other men. They were less likely to be unemployed.*
- *36% reported a problem with alcohol, 49% had either alcohol or drug misuse or both; this was particularly common for men who were unemployed, bereaved, and had a history of violence or self-harm.*
- *Many had experienced adverse life events within 3 months of death, including problems with family relationships (36%), finance (30%), housing (28%), or the workplace (24%). Overall, 57% were experiencing economic problems - unemployment, finance or accommodation - at the time of death.*
- *(9%) men reported accommodation problems (i.e., being asked or threatened with having to leave their home)*
- *91% of middle-aged men had been in contact with at least one service or agency at some time preceding their death. This was most often with primary care (i.e. GP; 199, 82%)*
- *The most common method of suicide was hanging/strangulation, accounting for 61% of all suicides by middle aged men.*

15.8.4 Elizabeth Bates research (Bates, 2019) into 'Men and Intimate Partner Violence (IPV)' identified: *Men who had suffered IPV reported suffering physical injuries, loss of self-worth, and suicide ideation (Tsui 2014). Other studies have included associations with binge drinking (Hines & Straus, 2007) and with posttraumatic stress disorder (PTSD, e.g., Hines & Douglas, 2011). This research indicates that men suffer psychological and physical effects of IPV victimization.*

15.8.5 COVID appears to have also impacted Adam's mental wellbeing and may have been a contributing factor to taking his life. A study commissioned by the Home Office with regards to Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020 – 2021[19] found victims described 7 themes where Covid-19 impacted on the domestic abuse they were experiencing. Identified within these there are some pressures Adam was experiencing:

Theme 4 – Situational Pressures arising from Covid exacerbating existing conflict or abuse:

- Finances or job being affected by Covid-19 restrictions (unemployment, furlough)
- Home-schooling / childcare impacted.

Theme 5 – Limited ability to reach out for help:

- Isolation and the lockdown requirement to 'stay at home' preventing some victims from help-seeking

Theme 7: Reduced ability to manage conditions at home:

- Suspect access to alcohol or drugs being reduced (either to the substances themselves where dependent, or to support services)

[19] https://www.gov.uk/government/publications/domestic-homicides-and-suspected-victim-suicides-during-the-pandemic

- Suspect mental health issues worsening, and/or access to mental health support diminishing (range of contexts: reporting Covid-19 induced anxiety, feeling unable to cope, psychosis/severe mental health conditions worsening). Police specifically noted a lack of capacity from Mental Health teams – especially crisis teams - to adequately support both victims and suspects.
- Victim or suspect's individual coping mechanisms affected – e.g., external opportunities for 'blowing off steam' reduced.

15.8.6 The study found 72% of victims in cases of suspected victim suicide were aged under 45, additionally, 95% the most common risk factor was perpetration of domestic abuse and coercive and controlling behaviour which it appears Adam may have been experiencing.

15.9 COVID

15.9.1 During the pandemic government schemes supported families who were financially affected by the pandemic. Adam mentioned he had accessed the furlough scheme; however, it is unclear if Adam and Sarah accessed any other schemes to alleviate some of the stressors they may have been experiencing.

15.9.2 This review acknowledges that although there appears to have been domestic abuse within this relationship, the couple (as were the country) were also experiencing a unique phenomenon which can only have exasperated the dynamics and pressures within the relationship and at home.

15.9.3 Home-schooling during the pandemic may have impacted the school's response to any concerns, however they were not being home-schooled at the time of Adam's death. The response of other organisations to Adam and Sarah do not appear to have been impacted by COVID.

16 Conclusion

16.1 There is no evidence that Adam had ever made any allegations of domestic abuse until after their relationship had ended whereas there had been several allegations of domestic abuse previously made by Sarah. This is not to say Adam had not been a victim of domestic abuse post separation.

16.2 Opportunities were missed with Adam and the rest of the family to explore what was happening within the relationship and other causal contributions to his suicidal thoughts. Professional curiosity was the key missing element by agencies to explore the situation at home and how this could have been risk assessed and support offered to both Adam, Sarah, and their children.

16.3 Within this case there were two people presenting as victims accusing the other as the perpetrator which can be difficult for professionals to evaluate. There are tools available for professionals to use which were not utilised with Adam and Sarah and may have benefited those risk assessing and offering support to both. It is therefore important for agencies to know where to seek advice and guidance to help inform their risk assessing and decision making.

16.4 This family were hidden in plain sight, they shared information with different agencies, but this was held in isolation, never raising concerns, meaning appropriate risk assessments and offers of support and interventions were missed.

16.5 The finality moment for Adam appears to have been when Sarah informed him of her new relationship, confirming the end of his marriage and the loss of his wife.

16.6 Upon arrival to the scene after Adam's death officers recorded within their log 'Adam *was described as being calm and called Sarah's new on his mobile and had a 15–20-minute conversation with him before leaving the house at around 18:30*.' This conversation could not have been easy for Adam, and it is possible the impact of this conversation on Adam may have been a significant trigger of an increased sense of loss and helplessness.

16.7 According to Police records after this conversation Adam drank alcohol with a friend. Alcohol is a known depressant and, although probably used to ease the pain he was feeling, it is possible it would have heightened his anxieties, increased his impulsivity, and clouded his judgement. A government report on alcohol and mental health (O'Connor, 2020) identified '*a quarter of those who were alcohol dependent were likely to be receiving mental health medication, mostly for anxiety and depression, but also for sleep problems, psychosis and bipolar disorder. Additionally, they found people in touch with specialist mental health services who also have a history of alcohol problems can be at elevated risk of death by suicide*'.

16.8 Although Adam was not in contact with specialist mental health support services, he was experiencing anxiety, lack of sleep and additional factors impacting his mental health. It is important professionals can recognise the signs of suicidal thoughts, identify these risks and be able to offer support to those in need.

16.9 Bessel Van Der Kolk MD states, "*If a trauma victim is unable to imagine an alternative future, then they have no place to go*" and "*sometimes after being exposed to a traumatic experience, people feel immobilized and have a hard time finding purpose and pleasure in their current life, and focus, instead, on their traumatic past*"[20]. Adam had experienced several traumatic incidents over the last 18 months of his life such as the death of his mother, the pandemic, domestic abuse, and the end of his relationship. This may explain how he was feeling unable to see an alternative future with suicide as his only option.

16.10 Finally, Adam and Sarah's 2 children have experienced significant trauma before and since their father's death including:

- The loss of their Father
- Parental Conflict
- Domestic Abuse
- Their fathers misuse of alcohol
- Adam's mental health
- The death of their paternal grandmother
- COVID

16.11 Each experience above is an Adverse Childhood Experience[21] (ACE). The impact of a high ACE score (4 or more) can affect how children perceive themselves, how they interact with others, how they cope with the emotional pain, may leave them confused, have trust issues and difficulty to form relationships and have boundaries. Therefore, the offer to work with the

[20] https://www.besselvanderkolk.com/resources/the-body-keeps-the-score
[21] https://www.cdc.gov/violenceprevention/aces/index.html

children and Sarah by specialist services as well as statutory professionals should be offered so they are able to understand the trauma they have experienced, with the aim to reduce the impact and provide them with stability to improve their future.

17. Learning

17.1 Learning Point 1

17.1.1 After the family had been identified as high risk and moved to Somerset best practice would have been for a MARAC-to-MARAC referral to have been made. At the time of the move the family were only involved with education and health. Education were unaware of the MARAC therefore would have been unable to make the referral or shared information with the new schools. The GP and health visitor would have been the only agency able to make this referral but may not have been aware of the MARAC-to-MARAC process.

17.1.2 At the time of the move there had been no further incidents reported or concerns raised by the family or professionals, and it was 12 months after being discussed, therefore it may have been considered not suitable for a MARAC-to-MARAC referral.

17.1.3 Safelives 'MARAC to MARAC transfer process' states 'the MARAC Coordinator is to make the referral'. There is little guidance to support whether other professionals can make the referral or a timeframe of when a referral can be made.

17.2 Learning Point 2

17.2.1 There was minimal awareness and understanding of domestic abuse, its complexities, recognising the signs, disclosures and the trauma associated with it by school staff.

17.2.2 Developing greater awareness and confidence in dealing with the variety of situations that can arise with domestic abuse such as disclosures by children or where professional curiosity is required to investigate further and appropriate referrals and signposting is provided.

17.2.3 Both schools immediately identified this learning. Domestic abuse training has been provided to both Head Teachers and other teaching staff with a plan to ensure this is rolled out to all staff. Both schools are also currently looking at developing a domestic abuse policy.

17.3 Learning Point 3

17.3.1 Due to the case being identified as a MISPER, there was no further exploration by the call handler regarding Sarah's fear and to discuss domestic abuse.

17.3.2 It was an opportunity to have created a separate incident of domestic abuse which may have enabled a more supportive response to both Adam and Sarah.

17.4 Learning Point 4

17.4.1 There is currently a gap in sharing of information with GP's where there is domestic abuse and no children and/or how information is shared when there are mental health concerns for adults who come to police attention.

17.4.2 Somerset are currently piloting a 1-year project where domestic abuse PPNs (that include children) are sent to a designated person for their GP records to be flagged. This process will then be extended to include information sharing for adults with no children with the long term to find a digital solution to make this information sharing an automated process.

17.5 Learning Point 5

17.5.1 Although officers do not appear to have been aware of Sarah's fear of Adam, their conversation with her was an opportunity to explore the additional complexities regarding the relationship, any domestic abuse, complete the DASH RIC and offer support.

17.6 Learning Point 6

17.6.1 The Police and Sarah had a long conversation over the phone (we have not seen any transcript or the details of this conversation) and a decision was made there were no offences committed, even though texts were never seen, and no statement was taken or Adam spoken to.

17.6.2 Sarah indicated she did not want Adam arrested; however, it is not evident whether the officer offered to meet with her to view the messages, see the home environment and create a timeline to accurately record any offences, offer support and speak with Adam.

17.7 Learning Point 7

17.7.1 Developing greater awareness and confidence in dealing with the variety of situations that can arise with domestic abuse such as disclosures from men and dual allegations would support robust assessments and interventions.

17.8 Learning Point 8

17.8.1 Adam and those around him may not have identified him as a victim of domestic abuse and this may have been due to lack of awareness but also societal perception of how a 'man should behave' and the barriers that can create for male victims seeking support.

17.8.2 Public Awareness has also been identified in The Tackling Domestic Abuse Plan 2022 Problem Four – *'Identifying more domestic abuse cases. Currently there are gaps in public awareness of what constitutes domestic abuse, which hinders identification of cases. Increasing the ability of professionals to identify and respond to domestic abuse cases, particularly those more likely to regularly encounter them, should also contribute to identification of more cases. And the system needs to provide more opportunities for victims and survivors to disclose abuse by addressing the reasons why they do not do this. These include not knowing if or where support existed or how to access it*.' Therefore, it is vital to recommend this is incorporated within any domestic abuse strategy.

17.9 Learning point 9

17.9.1 The LSU's decision not to contact Sarah was a missed opportunity for her to access support All staff within the LSU have been reminded to ensure that the rationale for not contacting a victim is documented and that contact decisions are based on classifications rather than other detail in the incident log (occurrence) in future.

17.10 Learning Point 10

17.10.1 Adam was experiencing many pressures and disclosed how this was impacting on his mental health, but he made no disclosure of suicidal thoughts to the professionals he encountered. Where a disclosure of mental health concerns is received, it is essential all options are discussed and offered.

17.10.2 It is imperative services understand that not all those with suicidal thoughts have mental health 'issues' or require mental health support. When a person makes a disclosure that they are considering suicide or there are concerns for the persons wellbeing agencies need to ensure their staff are skilled to recognise signs and can explore contributing factors to these thoughts. Additionally, staff must be aware of the variety of local and national support, advice, and options available, enabling the person to have 'agency' over their decisions and feel in control.

17.10.3 Domestic Abuse can have a lasting and devastating impact and for some the only way they feel they can escape or gain control is by taking their own life. The Somerset Suicide Prevention Partnership Forum is the multi-agency group that coordinates suicide prevention work in the county, it is imperative this forum work with the domestic abuse board to create a coordinated approach to those in need.

17.11 Learning Point 11

17.11.1 There were allegations of domestic abuse within this family, the children had made disclosures of fear, sadness, and possible violence. There were possible financial concerns, misuse of alcohol and deterioration of Adam's mental health. Information was held in isolation by individual agencies, on their own they did not raise concerns, however, if shared it may have highlighted a bigger picture for the family.

17.11.2 Think Family (Avon and Somerset's County response to the national Troubled Families initiative) required eligible families to meet at least 2 of the following 6 criteria:

- Parents and children involved in crime or ASB
- Children who have not been attending school regularly
- Children who need help
- Adults at risk of financial exclusion or young people at risk of workless-ness
- Families affected by Domestic Abuse
- Parents and children with a range of health problem.

17.11.3 Where there are children involved and there is the possibility the family may benefit from intervention from the Think Family Initiative an enquiry or referral ought to be made. This would enable partnership working, sharing of information and possible support for the entire family.

18. Recommendations

18.1 Recommendation 1

Review of MARAC policy to include '*when agencies become aware there has been a MARAC in another area, enquiries are to be made for a referral to be made to Somerset MARAC'*. Once amended a clear procedure and training is to be offered to partner agencies.

18.2 Recommendation 2

Education Safeguarding to become integral partners of MARAC and share actions and information with schools to support the safety and action plans for victims.

18.3 Recommendation 3

Domestic abuse to be stand-alone training for all members of educational staff to understand behaviours, complexities surrounding domestic abuse, the DASH RIC, the domestic abuse pathway, and support available within the county.

18.4 Recommendation 4

Education Safeguarding to make Somerset Council On-line Domestic Abuse Training mandatory to all staff in Somerset schools.

18.5 Recommendation 5

Schools to review the effectiveness of training in terms of impact, partnership working, referrals and safeguarding.

18.6 Recommendation 6

Domestic abuse is to be included within Educations Annual Safeguarding Audit.

18.7 Recommendation 7

Education Safeguarding to attend the Domestic Abuse Board and carry out the domestic abuse Audits required.

18.8 Recommendation 8

Review the Call Handling Grading and Deployment Operational Procedure to try and identify those messages that present the greatest risk and require a prompt attendance.

18.9 Recommendation 9

To adopt and implement the college of policing guidance to responders and call takers for stalking and harassment offences. All staff within the control room to receive training and use the College of Policing question set to determine risk along with the THRIVE risk assessment principles.

18.10 Recommendation 10

Officers to ensure they offer a variety of options with regards to speaking with victims especially when there may be reluctance or a possibility of minimisation. Officers need to be proactive in seeking evidence to support the safety of victims and prosecute those using abusive behaviours.

18.11 Recommendation 11

Training offered to include local domestic abuse services and specialist male victim services promoting partnership working with the most up to date information and support.

18.12 Recommendation 12

Training to include how to identify primary victims and perpetrators when there are dual allegations.

18.13 Recommendation 13

Develop a co-ordinated and multi-agency awareness campaign and roll out to the community and professionals regarding domestic abuse and to include male victims and the impact on mental health and suicide.

18.14 Recommendation 14

LSU to increase supervisory oversight of cases through audits and dip sampling to increase consistency in decisions to contact victims of domestic abuse where a crime is recorded.

18.15 Recommendation 15

Although Open Mental Health is available to find online there needs to be positive work raise awareness in other forms ensuring those who may not have access to the internet or social media can seek information of the support available.

18.16 Recommendation 16

The Suicide Prevention Partnership Forum will ensure that a representative from the Domestic Abuse Partnership is invited to forum meetings which occur quarterly.

18.17 Recommendation 17

A representative from the Domestic Abuse Partnership (alongside other professionals within the field) are to be invited to sit on the Suicide Prevention Partnership Forum working group for the High-Risk Groups workstream when they focus on domestic abuse.

18.18 Recommendation 18

A member from the Somerset Suicide Prevention Partnership (Public Health or other relevant agency) is to be invited as a panel member for any future domestic abuse suicide reviews within Somerset.

APPENDIX 1

Reference list

https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL_1.pdf?msclkid=770463f4ceac11ec8f0466908e13260a

https://www.legislation.gov.uk/ukpga/2004/28/section/9

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Executive Summary

Domestic Abuse Death Review

Adam died June 2021

Chair and Author
Katie Bielec

Review completed
January 2023

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1 INTRODUCTION

1.1 Safer Somerset Partnership, the independent chair and panel members want to offer their deepest sympathy and condolences to Adam's family and friends. The chair would also like to thank all those who contributed to the review, for their honesty, time, reflection, and support.

1.2 This summary outlines the process undertaken by Safer Somerset Partnership Domestic Homicide Review panel in reviewing the suicide of Adam who was a resident in their area.

1.3 In line with Home Office Statutory Multi-Agency Guidance[22] paragraph 75, to protect the identity of the victim, perpetrator, relevant family members and others to comply with the Data Protection Act 1998 pseudonyms have been used.

1.4 In June 2021 Adam died as a result of suicide he was 45 years old. He had been married to Sarah (who was 47 years old at the time of his death) for 10 years and they had 2 children. In the summer of 2020, they separated and they continued to live in the family home together, however, Adam on occasion stayed with friends. Throughout the marriage there had been allegations of domestic abuse made by both Adam and Sarah.

1.5 Avon and Somerset Constabulary informed Safer Somerset Partnership of Adam's death and a decision to conduct a Domestic Homicide Review was agreed in July 2021 with the aim of completing the review in April 2022. Panel meetings were held on October 2021, January, March and May 2022.

1.6 The Home Office Multi-Agency Statutory Guidance for Domestic Homicide Reviews December 2016 in paragraph 46 states that the target timescale for completion of the Review of six months may need to be extended in complex cases. Due to circumstances caused by a combination of the complexities of the case and the impact of Covid-19 this review surpassed 6 months, with the approval of the Panel and Safer Somerset Partnership.

1.7 The panel made a unanimous decision that due to Adam taking his own life the review would be named a Domestic Abuse Death Review, however it continued to follow the Domestic Homicide Review guidance.

1.8 Sarah was informed of the review via letter, email and via both schools which included information of the charity Advocacy After Fatal Domestic Abuse[23] (AAFDA) to offer support through the process. An introduction to the chair was made and offers of dates to meet in person (both schools were able to provide a venue should Sarah feel more comfortable there) as well as virtually.

1.9 Sarah acknowledged the review and explained to the school she did not feel able to be participate, the offer remained open throughout the process.

1.10 Due to the ages of Adam and Sarah's children, a decision was made not to speak with them. Attempts were made to identify Adam's friends and family; the coroner was contacted but was unable to provide any family contacts, and although professionals believe Adam had a brother no contact details ascertained.

[22] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews
[23] https://aafda.org.uk/

1.11 The Inquest was held in November 2021, based on the evidence available, Adam's death was concluded to be as a result of suicide.

1.12 There were no other reviews being conducted at the time of this review.

2 CONTRIBUTORS TO THE REVIEW

2.1 The Domestic Abuse Death Review has been compiled from information and facts from the following IMRs[24]:

- Hampshire Constabulary
- Hampshire Children Social Care
- Avon and Somerset Constabulary (ASC)
- Somerset Integrated Care Board (ICB) (previously Somerset Clinical Commissioning Group)
- Somerset Education – Primary School and Independent School
- Discussions from the Review Panel meetings

2.2 The panel consisted of statutory partners as well as those who were identified to have expertise and were able to add value in the discussion and the report. A suicide prevention specialist was absent from the panel, however, to support the review the Health Improvement Manager for Public Health (lead for Suicide Prevention) was consulted with and supported the analysis, learning and recommendations. All panel members were required to review each IMR, provide feedback at panel meetings and support the process.

2.3 The review panel consisted of:

Name and Job Title	**Agency**
Katie Bielec - Independent Chair and Report Author	Bielec Consultancy Limited
Suzanne Harris - Senior Commissioning Officer	Somerset Council
Su Parker - A/Detective Inspector	Avon and Somerset Constabulary
Emma Read - Designated Nurse Adult Safeguarding	Somerset Clinical Commissioning Group
Heather Sparks - Named Professional for Safeguarding Adults	Somerset NHSFT
Mark Brooks - Chair of Trustees	Mankind Initiative
Kelly Brewer - Team Manager	Somerset Children Social Care
Claire Chantler - Executive Head Teacher	Beckington School
Sally Cox - Head Teacher	Springmead School
Steve Kensington - Area Manager West	The You Trust - SIDAS
Jane Harvey-Hill – Team Manager	Inclusion – SDAS

* Education Safeguarding were invited to the panel members but did not attend.

3 INDEPENDENT CHAIR AND AUTHOR

3.1 Katie is an independent domestic abuse consultant providing support and training to councils and businesses across England and chairs MARAC[25], MARMM[26] and stalking clinics. She is an associate trainer for Safelives, Rockpool, The Hampton Trust, a guest lecturer for

[24] IMR Individual Management Reviews by each of the agencies defined in Section 9 of the Domestic Violence Crime and Victims Act (2004)
[25] MARAC - Multi-Agency Risk Assessment Conference information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.
[26] Multi Agency Risk Management Meetings

Bournemouth University and is an accredited trainer delivering Coercive Controlling Behaviour and Stalking Awareness.

3.2 Katie was previously a Metropolitan police officer for 5 years working in a variety of roles and is a qualified IDVA, IDVA manager, ISVA[27] Manager and has managed domestic abuse services across the southwest between 2010 and 2021 with The You Trust. Although the You Trust are panel members and were the provider of the domestic abuse service within Somerset at the time of Adam's death, however they were not involved with either Adam or Sarah. Katie was not connected with this either in Hampshire or Somerset project and was the manager of the Dorset Domestic Abuse Service. Since leaving the You Trust Katie has worked independently from trust.

3.3 Katie has completed the Home Office Domestic Homicide Review Training, is an accredited chair with AAFDA, a member for AAFDA DHR Network, Standing Together Against Domestic Abuse Coordinated Community Response (CCR) and The Employers Initiative on Domestic Abuse (EIDA)

3.4 Katie is not associated in any way to Adam or Sarah or the family.

4 SUMMARY CHRONOLOGY

4.1 Due to the review being unable to speak with any family or friends the chronology has been informed by the chronologies provided within the IMRs.

4.2 In early February 2017 whilst the family were living in Hampshire Sarah made allegations to the police of a physical assault and previous strangulation by Adam. Adam was arrested, Sarah was risk assessed and identified as high risk. She was referred to the MARAC, IDVA, National Centre for Domestic Violence[28] (NCDV) and Children Social Care. Target hardening and refuge was offered however this was declined with Sarah informing officers she did not fear for her safety.

4.3 A Child and Young Person Report (CYPR) was completed in line with FPP 01911 (process to identify and share with relevant partners details of any child at risk due to being present or linked to a domestic abuse incident) as the children were present at the time of the incident.

4.4 The MARAC was held several days after the incident, present were: Police, You Trust (commissioned IDVA service), Community Rehabilitation Company (this is now back under the National Probation Service), Health Visiting Service provided by Southern Health Foundation Trust, the local hospital, Inclusion (substance misuse), Adult services and Hampshire Fire and Rescue. CSC and Education were not present. The action from the MARAC was for the health visitor to ensure the GP records were updated to flag Sarah as high risk of domestic abuse.

[27] Independent Sexual Violence Advocate

[28] NCDV – National Centre for Domestic Violence an organisation to support those who wish to obtain a Non-Molestation and/or Occupation Order.

4.5 The incident was referred to Hampshire Children Social Care, they had no record of the MARAC, therefore completed their assessment with the PPN[29] and DASH[30] (with a score of 9 provided by Hampshire Constabulary. A short time after the incident the Police also raised with Children Social Care of concerned that Sarah was minimising the abuse. The social workers assessment stated they felt Sarah had not minimised, there was no risk to the children and the case was closed.

4.6 Adam received a conditional caution after Sarah provided a statement does not want to continue with the complaint. The domestic assault was recorded on the PNC[31] and PND[32] , unfortunately, PND records did not include information that the case was high risk and heard at MARAC. Additionally, Adam's details were entered incorrectly on PNC.

4.7 In June 2017 Adam attended his GP with Sarah to raise concerns regarding his misuse of alcohol, they appeared supportive of each other, and Adam was referred to a Recovery Centre for support for his alcohol addiction, however, it is unclear if he engaged with this intervention.

4.8 The family moved to Somerset in January 2018, Sarah informed the children's school there had been domestic abuse and the move had been for a new start. The school received the Hampshire children social care assessment and police DASH but were unaware of the MARAC.

Sarah was seen by the health visitor in March 2018 for an initial 'transfer in contact' (e.g., when someone new moves to area). This was the only time she was seen by the health visiting team. The health visitor obtained information from GP records noting that Sarah had been a victim of domestic abuse in 2017 and added an alert on the system.

4.9 In June 2018 Adam was invited to his GP for a review for hypertension they had a detailed conversation, Adam recognised he smoked and drank heavier than the healthy amount and was provided details of Smoke Free Somerset. He agreed he would try a healthier lifestyle for 2 months. There was no evidence of a conversation of a referral to alcohol support or any reason to raise concerns around domestic abuse.

4.10 Neither Adam or Sarah contacted their GP until September 2019 when Adam informed his GP, he had not drunk alcohol for 6 weeks and was feeling much better. There appeared to be no disclosure or conversation regarding domestic abuse, in fact the notes indicate Adam stating his relationship with Sarah was happy and well.

4.11 In February 2020, the family's youngest child was heard at school threatening to cut another child's throat open, when spoken to by a teacher he told them it was how he always played. No concerns were raised and neither parent was spoken to.

[29] PPN - Public Protection Notice is a document embedded in Niche which summarises the vulnerabilities of an individual, which then forms the basis for a risk assessment for that individual.
[30] DASH (Domestic Abuse, Stalking and "Honour"-based violence) is a commonly accepted tool which supports front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence.
[31] PNC – Police National Computer
[32] PND – Police National Database

4.12 Shortly after this incident there was a global pandemic, and the nation went into a lockdown from 23/3/2020 – 10/5/2020. During the lockdown, the children were home schooled and were spoken to weekly by teachers.

4.13 A concern was raised by the school at the end of June 2020 when the youngest child drew a picture of him feeling scared. He disclosed his Daddy shouted at Mummy and it made him scared. The teacher raised this with the schools designated safeguarding lead and a decision was made to monitor the situation, at no stage was a parent spoken to.

4.14 Early in July 2020 the children were absent from school and a member of staff spoke with Sarah. She told them she was in Wales with her family as the relationship with Adam had deteriorated over lockdown, the arguments and shouting had got worse and Adam was drinking in the pub. Sarah disclosed she had asked him to leave the family home, however, he had refused as his mother was living with them as she had terminal cancer. During the conversation she stated she would have to come back to the home due to not being able to afford the divorce and because of the boys.

4.15 After the 2020 summer holidays, the eldest did not return to the primary school and was placed in a local independent school. He settled in well; however, the original school had been surprised by the move as Sarah had told them she wanted him to stay.

4.16 It is unclear when but during the summer or early autumn of 2020 Adam's mother passed away.

4.17 On 11/11/2020 the nation went into a second national lockdown.

4.18 2 weeks after this Sarah contacted police concerned for Adam's welfare after friends had informed her that that he had tried to take his own life a few weeks previously.

4.19 During the call Sarah stated she was frightened if Adam returned to the to the family home and requested the address was flagged.

4.20 The case was correctly recorded as a MISPER[33], Police located Adam safe and well, he was staying with friends and disclosed his relationship had broken down.

4.21 Officers spoke to Sarah are speaking with Adam, she described home as unhappy and unhealthy. There does not appear that domestic abuse was discussed and there is no evidence they spoke to her regarding her disclosure of being frightened of Adam. No DASH RIC or BRAG[34] was completed and no onward referrals were made by the police as per Avon and Somerset Domestic Abuse Policy and Procedure.

[33] MISPER, a term commonly used to describe a missing person. If a person is deemed to be missing, it initiates a set of actions based on the risks to the person missing.

[34] BRAG A tool introduced in 2018 to objectively risk assess and record all forms of vulnerability or safeguarding concerns. The outcome of the BRAG assessments helps determine immediate action as well as helping LSU to triage and signpost or refer to appropriate partner agencies. It should be used alongside other assessment tools (such as the DASH), and its use is subject to continual compliance monitoring via the Qliksense App.

4.22 The day after this call Adam sought support from his GP, explained lockdown had played havoc with his mental health and he felt sad and anxious. He had a low appetite, sleep disturbance, he had furloughed himself due to being self-employed, his marriage was on the 'rocks', he was staying with friends and had commenced counselling. Sertraline was prescribed for his anxiety and depression as he felt they helped him last time. The GP noted Adam had shared he had on occasional thought of not wanting to be here, but his friends were very supportive. Adam appeared to have been open with the GP with detailed notes of the conversation, however, he made no reference of his contact with the police the previous day or make any disclosure of experiencing domestic abuse.

4.23 Early in December 2020 a school teacher raised a concern for the youngest child's well-being as he was often sad, withdrawn and finding life hard. Sarah was spoken to, she described being tired, home was awful due to the divorce and that Adam had been back to the house the night before for the first time in a long time.

4.24 Also, in December the older child's school spoke to Sarah who them things were difficult at home and had been for a long time. She asked for them to keep an eye the child, the teacher and teaching assistant were informed of the conversation but did not notice a change in the child's behaviour.

4.25 Later that month the police received a call from Sarah to report verbal and emotional abuse from Adam. She reported he had called her over 20 times in an hour whilst she was out, shouting and wanting to know when she would be back and that he had told their children she had left them, getting them to leave messages. She informed them he had since left the property to stay with a friend. The call was upgraded from 'Routine' to 'Priority Attendance', units were advised to check in advance of attendance to ensure Adam was not home, however, no units were available to attend due to operational demand and Sarah was not contacted until 36 hours later.

4.26 Sarah explained to the officer who contacted her that Adam's behaviour had become difficult since she told him she wanted to end their marriage; he drank excessively, had become controlling asking where she was and why she was going out, thinking she had met someone. Sarah did not want to make a formal complaint; therefore, Adam was not spoken to.

4.27 The officer recorded this incident as '*no offences identified*', a DASH RIC was completed as standard, and a BRAG was completed with a result of Green. NCDV information was provided, an internal referral to the LSU[35] was made and Education Safeguarding and Children Social Care were made aware.

4.28 The LSU did not attempt to contact Sarah, no reason was provided for this decision. It is believed the decision was influenced due to the officer stating no offences to investigate which is not in keeping with Avon and Somerset Constabulary (ASC) Process. At no stage was Adam spoken to.

4.29 A few days before Christmas 2020 (4 days after Sarah called police) Adam attended a local police station to report Sarah had threatened she would make false allegations to get him arrested if he did not pay her more money. Adam wanted information logged in case Sarah called police.

[35] Lighthouse Safeguarding Unit a joint team with a joint function of supporting victims and witnesses of crime (including onward referral to other agencies and, where appropriate, being a point of contact during a Criminal Justice System processes) alongside safeguarding overview. It provides a streamlined approach to supporting individuals by improved ways of working with partners to safeguard the most vulnerable. The team offers an enhanced service to vulnerable, intimidated or persistently targeted victims of crime and anti-social behaviour as well as to victims of serious crime.

4.30 An officer contacted Adam the same day, Adam stated Sarah was a good mother, respected her decision (to start divorce proceedings) but wanted the separation to be amicable and completed asap.

4.31 He was advised to seek legal advice; a DASH was completed as standard, and the incident was classified as blackmail. Adam was offered support, but this was refused along with his details being shared. However, an internal referral was completed to the LSU, who attempted to contact Adam twice. At no stage was Sarah spoken to.

4.32 The eldest child's school received the PPN in December, they spoke with Sarah, who informed them things had settled down. They offered her support and informed Sarah they would be keep an eye on the child in the new term. No call was made to Adam to offer the similar support.

4.33 Neither child returned to school after the Christmas, as the nation went into the 3rd lockdown on 6/1/2021. The eldest child's school offered a place however this was declined.

4.34 There was a staged exit of lockdown with different easing restrictions dated 8/3/2021, 12/4/2021 and 17/5/2021.

4.35 Mid-May 2021 Adam called 999 from the home landline following an argument with Sarah, he reported she had taken his phone and smashed it. He alleged Sarah used cocaine whilst caring for the children, had caused bruising to her own body, falsely alleged he had been violent towards her, and he had received threats and verbal abuse from Sarah and her parents. The call was graded priority and tasked for attendance; however, he informed police he was not available that evening but was keen to speak as he was concerned Sarah would make allegations against him.

4.36 Due to service demands Adam was not seen immediately, there were several calls between both Adam and police, however, Adam was unavailable to meet officers due to having the children. Officers advised Adam to consider his and the children's safety and to leave the property, he reported he was not at risk of physical harm and was suffering emotional abuse. Police made a final attempt to call Adam on 1/6/2021, however, there was no further contact with him.

4.37 A few weeks into June 2021 Adam was informed by Sarah that she had started a relationship with a family friend. Adam called Sarah's new partner and (according to officer's notes) and had a calm conversation with him for about 15-20 minutes.

4.38 Adam then left the family home early that evening, where he allegedly went to a neighbour's house and drank alcohol. When he returned home later that evening, he handed Sarah a letter and wanted to talk, but she refused (the detail of the letter was unavailable for the review).

4.39 He went to his youngest child's bedroom to sleep (this was apparently usual at the time), their child was sleeping in the same room as Sarah due to Adam's bed being covered with work clothes.

4.40 The following morning Sarah found Adam deceased. She called her boyfriend and a neighbour, the neighbour arrived, and the boyfriend called an ambulance.

4.41 The coroner in November 2021 concluded that in June 2021 at his home address in Somerset Adam deliberately suspended himself by the neck with the intention of ending his life.

5 LEARNING

5.1 Learning Point 1

5.1.1 After the family had been identified as high risk and moved to Somerset best practice would have been for a MARAC-to-MARAC referral to have been made. At the time of the move the family were only involved with education and health. Education were unaware of the MARAC therefore would have been unable to make the referral or shared information with the new schools. The GP and health visitor would have been the only agency able to make this referral but may not have been aware of the MARAC-to-MARAC process.

5.1.2 At the time of the move there had been no further incidents reported or concerns raised by the family or professionals, and it was 12 months after being discussed, therefore it may have been considered not suitable for a MARAC-to-MARAC referral.

5.1.3 Safelives 'MARAC to MARAC transfer process' states 'the MARAC Coordinator is to make the referral'. There is little guidance to support whether other professionals can make the referral or a timeframe of when a referral can be made.

5.1.4 During this period there were several opportunities where agencies had the opportunity to seek further information with regards to the relationship, supporting them in making risk led assessments and offering support and intervention. There is evidence of some positive practice, however there is also evidence of missed opportunities.

5.1 Learning Point 2

5.2.1 There was minimal awareness and understanding of domestic abuse, its complexities, recognising the signs, disclosures and the trauma associated with it by school staff.

5.2.2 Developing greater awareness and confidence in dealing with the variety of situations that can arise with domestic abuse such as disclosures by children or where professional curiosity is required to investigate further and appropriate referrals and signposting is provided.

5.2.3 Both schools immediately identified this learning. Domestic abuse training has been provided to both Head Teachers and other teaching staff with a plan to ensure this is rolled out to all staff. Both schools are also currently looking at developing a domestic abuse policy.

5.2 Learning Point 3

5.3.1 Due to the case being identified as a MISPER, there was no further exploration by the call handler regarding Sarah's fear and to discuss domestic abuse.

5.3.2 It was an opportunity to have created a separate incident of domestic abuse which may have enabled a more supportive response to both Adam and Sarah.

5.3 Learning Point 4

5.4.1 There is currently a gap in sharing of information with GP's where there is domestic abuse and no children and/or how information is shared when there are mental health concerns for adults who come to police attention.

5.4.2 Somerset are currently piloting a 1-year project where domestic abuse PPNs (that include children) are sent to a designated person for their GP records to be flagged. This process will then be extended to include information sharing for adults with no children with the long term to find a digital solution to make this information sharing an automated process.

5.4 Learning Point 5

5.5.1 Although officers do not appear to have been aware of Sarah's fear of Adam, their conversation with her was an opportunity to explore the additional complexities regarding the relationship, any domestic abuse, complete the DASH RIC and offer support.

5.5 Learning Point 6

5.6.1 The Police and Sarah had a long conversation over the phone (we have not seen any transcript or the details of the conversation) and a decision was made there were no offences committed, even though texts were never seen, and no statement was taken or Adam spoken to.

5.6.2 Sarah indicated she did not want Adam arrested; however, it is not evident whether the officer offered to meet with her to view the messages, see the home environment and create a timeline to accurately record any offences, offer support and speak with Adam.

5.6 Learning Point 7

5.7.1 Developing greater awareness and confidence in dealing with the variety of situations that can arise with domestic abuse such as disclosures from men and dual allegations would support robust assessments and interventions.

5.7 Learning Point 8

5.8.1 Adam and those around him may not have identified him as a victim of domestic abuse and this may have been due to lack of awareness but also societal perception of how a 'man should behave' and the barriers that can create for male victims seeking support.

5.8.2 Public Awareness has also been identified in The Tackling Domestic Abuse Plan 2022 Problem Four – 'Identifying more domestic abuse cases. Currently there are gaps in public awareness of what constitutes domestic abuse, which hinders identification of cases. Increasing the ability of professionals to identify and respond to domestic abuse cases, particularly those more likely to regularly encounter them, should also contribute to identification of more cases. And the system needs to provide more opportunities for victims and survivors to disclose abuse by addressing the reasons why they do not do this. These include not knowing if or where support existed or how to access it.' Therefore, it is vital to recommend this is incorporated within any domestic abuse strategy.

5.8 Learning Point 9

5.9.1 The LSU's decision not to contact Sarah was a missed opportunity for her to access support All staff within the LSU have been reminded to ensure that the rationale for not contacting a victim is documented and that contact decisions are based on classifications rather than other detail in the incident log (occurrence) in future.

5.9 Learning Point 10

5.10.1 Adam was experiencing many pressures and disclosed how this was impacting on his mental health, but he made no disclosure of suicidal thoughts to the professionals he encountered. Where a disclosure of mental health concerns is received, it is essential all options are discussed and offered.

5.10.2 It is imperative services understand that not all those with suicidal thoughts have mental health 'issues' or require mental health support. When a person makes a disclosure that they are considering suicide or there are concerns for the persons wellbeing agencies need to ensure their staff are skilled to recognise signs and can explore contributing factors to these thoughts. Additionally, staff must be aware of the variety of local and national support, advice, and options available, enabling the person to have 'agency' over their decisions and feel in control.

5.10.3 Domestic Abuse can have a lasting and devastating impact and for some the only way they feel they can escape or gain control is by taking their own life. The Somerset Suicide Prevention Partnership Forum is the multi-agency group that coordinates suicide prevention work in the county, it is imperative this forum work with the domestic abuse board to create a coordinated approach to those in need.

5.10 Learning Point 11

5.11.1 There were allegations of domestic abuse within this family, the children had made disclosures of fear, sadness, and possible violence. There were possible financial concerns, misuse of alcohol and deterioration of Adam's mental health.

5.11.2 Fragments of information were held in isolation by individual agencies. On their own they did not raise concerns, however, if shared it may have highlighted a bigger picture for the family.

5.11.3 Think Family (Avon and Somerset's County response to the national Troubled Families initiative) required eligible families to meet at least 2 of the following 6 criteria:

- Parents and children involved in crime or ASB.
- Children who have not been attending school regularly
- Children who need help
- Adults at risk of financial exclusion or young people at risk of workless-ness
- Families affected by Domestic Abuse
- Parents and children with a range of health problem.

5.11.4 Where there are children involved and there is the possibility the family may benefit from intervention from the Think Family Initiative an enquiry or referral ought to be made. This would enable partnership working, sharing of information and possible support for the entire family.

6 CONCLUSION

6.1 There is no evidence that Adam had ever made any allegations of domestic abuse until after their relationship had ended whereas there had been several allegations of domestic abuse previously made by Sarah. This is not to say Adam had not been a victim of domestic abuse pre separation.

6.2 Opportunities were missed with Adam and the rest of the family to explore what was happening within the relationship and other causal contributions to his suicidal thoughts. Professional curiosity was the key missing element by agencies to explore the situation at home and how this could have been risk assessed and support offered to both Adam, Sarah, and their children.

6.3 Within this case there were two people presenting as victims accusing the other as the perpetrator which can be difficult for professionals to evaluate. There are tools available for professionals to use which were not utilised with Adam and Sarah and may have benefited those risk assessing and offering support to both. It is therefore important for agencies to know where to seek advice and guidance to help inform their risk assessing and decision making.

6.4 This family were hidden in plain sight, they shared information with different agencies, but this was held in isolation, never raising concerns, meaning appropriate risk assessments and offers of support and interventions were missed.

6.5 The finality moment for Adam appears to have been when Sarah informed him of her new relationship, confirming the end of his marriage and the loss of his wife.

6.6 Upon arrival to the scene after Adam's death officers recorded within their log 'Adam was described as being calm and called Sarah's new on his mobile and had a 15–20-minute conversation with him before leaving the house at around 18:30.' This conversation could not have been easy for Adam, and it is possible the impact of this conversation on Adam may have been a significant trigger of an increased sense of loss and helplessness.

6.7 According to Police records after this conversation Adam drank alcohol with a friend. Alcohol is a known depressant and, although probably used to ease the pain he was feeling, it is possible it would have heightened his anxieties, increased his impulsivity, and clouded his judgement. A government report on alcohol and mental health (O'Connor, 2020) identified 'a quarter of those who were alcohol dependent were likely to be receiving mental health medication, mostly for anxiety and depression, but also for sleep problems, psychosis and bipolar disorder. Additionally, they found people in touch with specialist mental health services who also have a history of alcohol problems can be at elevated risk of death by suicide'.

6.8 Although Adam was not in contact with specialist mental health support services, he was experiencing anxiety, lack of sleep and additional factors impacting his mental health. It is important professionals can recognise the signs of suicidal thoughts, identify these risks and be able to offer support to those in need.

6.9 Bessel Van Der Kolk MD states, “If a trauma victim is unable to imagine an alternative future, then they have no place to go” and “sometimes after being exposed to a traumatic experience, people feel immobilized and have a hard time finding purpose and pleasure in their current life, and focus, instead, on their traumatic past”. Adam had experienced several traumatic incidents over the last 18 months of his life such as the death of his mother, the pandemic, domestic abuse, and the end of his relationship. This may explain how he was feeling unable to see an alternative future with suicide as his only option.

6.10 Finally, Adam and Sarah’s 2 children have experienced significant trauma before and since their father’s death including:

- The loss of their Father
- Parental Conflict
- Domestic Abuse
- Their fathers misuse of alcohol
- Adam’s mental health
- The death of their paternal grandmother
- COVID

6.11 Each experience above is an Adverse Childhood Experiences[36] (ACE). The impact of a high ACE score (4 or more) can affect how children perceive themselves, how they interact with others, how they cope with the emotional pain, may leave them confused, have trust issues and difficulty to form relationships and have boundaries. Therefore, the offer to work with the children and Sarah by specialist services as well as statutory professionals should be offered so they are able to understand the trauma they have experienced, with the aim to reduce the impact and provide them with stability to improve their future.

7 RECCOMMENDATIONS

7.1 Review of MARAC policy to include; ‘when agencies become aware there has been a MARAC in another area, enquiries are to be made for a referral to be made to Somerset MARAC’. Once amended a clear procedure and training is to be offered to partner agencies.

7.2 Education Safeguarding to become integral partners of MARAC and share actions and information with schools to support the safety and action plans for victims.

7.3 Domestic abuse to be stand-alone training for all members of educational staff to understand behaviours, complexities surrounding domestic abuse, the DASH RIC, the domestic abuse pathway and support available within the county.

7.4 Education Safeguarding to make Somerset Council On-line Domestic Abuse Training mandatory to all staff in Somerset schools.

7.5 Schools to review the effectiveness of training in terms of impact, partnership working, referrals and safeguarding.

7.6 Domestic abuse is to be included within Educations Annual Safeguarding Audit.

[36] https://www.cdc.gov/violenceprevention/aces/index.html

7.7 Education Safeguarding to attend the Domestic Abuse Board and carry out the domestic abuse Audits required.

7.8 Review the Call Handling Grading and Deployment Operational Procedure to try and identify those messages that present the greatest risk and require a prompt attendance.

7.9 To adopt and implement the college of policing guidance to responders and call takers for stalking and harassment offences. All staff within the control room to receive training and use the College of Policing question set to determine risk along with the THRIVE risk assessment principles.

7.10 Officers to ensure they offer a variety of options with regards to speaking with victims especially when there may be reluctance or a possibility of minimisation. Officers need to be proactive in seeking evidence to support the safety of victims and prosecute those using abusive behaviours.

7.11 Training offered to include local domestic abuse services and specialist male victim services promoting partnership working with the most up to date information and support.

7.12 Training to include how to identify primary victims and perpetrators when there are dual allegations.

7.13 Develop a co-ordinated and multi-agency awareness campaign and roll out to the community and professionals regarding domestic abuse and to include male victims and the impact on mental health and suicide.

7.14 LSU to increase supervisory oversight of cases through audits and dip sampling to increase consistency in decisions to contact victims of domestic abuse where a crime is recorded.

7.15 Although Open Mental Health is available to find online there needs to be positive work raise awareness in other forms ensuring those who may not have access to the internet or social media can seek information of the support available.

7.16 The Suicide Prevention Partnership Forum will ensure that a representative from the Domestic Abuse Partnership is invited to forum meetings which occur quarterly.

7.17 A representative from the Domestic Abuse Partnership (alongside other professionals within the field) are to be invited to sit on the Suicide Prevention Partnership Forum working group for the High-Risk Groups workstream when they focus on domestic abuse.

7.18 A member from the Somerset Suicide Prevention Partnership (Public Health or other relevant agency) is to be invited as a panel member for any future domestic abuse suicide reviews within Somerset.

APPENDIX 1

TERMS OF REFERENCE

Aims of The Domestic Homicide Review Process

- Establish the facts that led to the death in June 2021 and whether there are any lessons to be learnt from the case about the way in which local professionals and agencies worked together to safeguard the family.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

To produce a report which summarises concisely the relevant chronology of events including:

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

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

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

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

Scope of the review

The review will:

- Consider the period from February 2017 to June 2021 (this is intended to cover the period from when an incident occurred in Hampshire which led to a MARAC referral and when Adam moved to the Somerset area in February 2018) subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events that are relevant.
- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Domestic Violence Crime and Victims Act (2004), and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family, employers, neighbours and friends to provide a robust analysis of the events. Taking account of the coroners' inquest in terms of timing and contact with the family.
- Aim to produce a report within 6 months of the DHR being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.
- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends

and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored

- To discover if all relevant civil or criminal interventions were considered and/or used.
- Determine if there were any barriers Adam or his family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
- Against the Equality Act 2010's protected characteristics.
- Consider what is 'good practice' for agencies to achieve in their response to domestic abuse for male victims.
- Is there a consistency in how agencies respond to victims of domestic abuse when both parties may present to an agency (possible "bi-directional abuse" and "counter-allegations"), is there any gender bias?
- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.
- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.
- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.
- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.
- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.
- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.
- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.
- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. In particular what were the effects of the Covid-19 pandemic on relevant organisations? Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.
- Consider the impact of Covid-19 on the family and accessibility of services.

Appendices

a. Action Plan

Please note, this action plan is a live document and will be subject to changes as outcomes are delivered.

Recommendation	Scope - Local or National	Actions	Agency	Key Milestones Achieved in Enacting Recommendation	Target Date	Date of completion and outcome
Review of MARAC policy to include; 'when agencies become aware there has been a MARAC in another area, enquiries are to be made for a referral to be made to Somerset MARAC'[37]. Once amended a clear procedure and training is to be offered to partner agencies.	Local	• Work with MARAC partners to produce and circulate amended procedure and training to professionals.	Project, Change & Improvement Officer in Public Health (Community Safety)	A new MARAC protocol has been written and is currently under review after being in place for 3 months	By April 2023	
Education Safeguarding to become integral partners of MARAC and share actions and information with schools to support the safety and action plans for victims.		• Somerset Domestic Abuse Partnership Board (SDAPB) representative to be invited to Education Sub-Group • Education Safeguarding to ensure they are active members of MARAC and they share information with schools in a timely manner, including them within any action plans created.	Senior Commissioning Officer Interpersonal Violence Education Safeguarding Project, Change & Improvement Officer in Public Health (Community Safety)	Education have signed the MARAC protocol and will be undertaking the 'onboarding' required to attend the MARAC in 2023	By April 2023	

[37] https://safelives.org.uk/sites/default/files/resources/MARAC%20to%20MARAC%20referral%20process%20FINAL.pdf

Recommendation	Scope - Local or National	Actions	Agency	Key Milestones Achieved in Enacting Recommendation	Target Date	Date of completion and outcome
Domestic abuse to be stand-alone training for all members of educational staff to understand behaviours, complexities surrounding domestic abuse, the DASH RIC, the domestic abuse pathway and support available within the county.	Local	• Schools to offer training opportunities to upskill all staff in the response to domestic abuse by providing Somerset Survivor training links.	Education safeguarding Head teachers of Beckington and Springmead Schools		By April 2023	
Education Safeguarding to make Somerset Council On-line Domestic Abuse Training mandatory to all staff in Somerset schools. (Vue App (somersetsurvivors.co.uk))	Local	• Education Safeguarding to review training of all school staff and include the on-line Domestic Abuse training within the mandatory portfolio.	Education safeguarding Head teachers of Beckington and Springmead Schools	The 2 schools involved within this review have implemented on-line domestic abuse training for staff and will continue to roll this out.	By April 2023	
Schools to review the effectiveness of training in terms of impact, partnership working, referrals and safeguarding.	Local	• Education to explore how to support supervisors within personal development on how to respond to domestic abuse (For example revision of Supervision and Case Management Policies)	Head teachers of Beckington and Springmead Schools		From April 2023	
Domestic abuse to be included within Educations Annual Safeguarding Audit.	Local	• Review the audit and amend to include data required by the Domestic Abuse Commissioners Officer for the DAPB to avoid duplicate data recording.	Education Safeguarding		From April 2023	

Recommendation	Scope - Local or National	Actions	Agency	Key Milestones Achieved in Enacting Recommendation	Target Date	Date of completion and outcome
Education Safeguarding to attend the Domestic Abuse Board and carry out the domestic abuse Audits required.	Local	• Attend the SDAPB and work with the board to implement learning and collect data as and when required.	Senior Commissioning Officer Interpersonal Violence (SCC)		From April 2023	
Review the Call Handling Grading and Deployment Operational Procedure to try and identify those messages that present the greatest risk and require a prompt attendance.	Local	• Liaise with College of Policing and other forces in how their call handling procedure could be amended, learning from best practice.	Improvement and Assurance Officer for *Domestic Abuse* (Avon and Somerset Constabulary)	All staff will attend DA Matters which will increase awareness of domestic abuse.	From April 2023	
To adopt and implement the college of policing guidance to responders and call takers for stalking and harassment offences. All staff within the control room to receive training and use the College of Policing question set to determine risk along with the THRIVE risk assessment principles.	Local	• Review the forces response to domestic abuse with those who receive initial calls from victims.	Improvement and Assurance Officer for *Domestic Abuse* (Avon and Somerset Constabulary)		From April 2023	
Officers to ensure they offer a variety of options with regards to speaking with victims especially when there may be reluctance or a possibility of minimisation.		• Explore how supervisors will oversee responses and officers' personal development around the response to domestic abuse after receiving DA Matters (For example	Improvement and Assurance Officer for *Domestic Abuse* (Avon		From April 2023	

Recommendation	Scope - Local or National	Actions	Agency	Key Milestones Achieved in Enacting Recommendation	Target Date	Date of completion and outcome
Officers need to be proactive in seeking evidence to support the safety of victims and prosecute those using abusive behaviours.		revision of Supervision and Case Management Policies)	and Somerset Constabulary)			
Training offered to include local domestic abuse services and specialist male victim services promoting partnership working with the most up to date information and support.	Local	• SDAPB to create a Comms and learning sub-group, members to include local and specialist services. • SDAPB to create a calendar of training, distribute with board members for wider circulation and feature on the Somerset Survivor Website.	Senior Commissioning Officer Interpersonal Violence (SCC) Senior Commissioning Officer Interpersonal Violence (SCC)	The chair of the Comms and Learning Sub-Group to update the SDAPB and be accountable for any actions.	From April 2023	
Training to include how to identify primary victims and perpetrators when there are dual allegations.		• Somerset Survivors Website to include the link to RESPECT Toolkit[38]. • SDAPB to provide training for professionals to feel confident in responding to dual allegations	Senior Commissioning Officer Interpersonal Violence (SCC) Senior Commissioning Officer		From April 2023	

[38] https://www.respect.uk.net/resources/19-respect-toolkit-for-work-with-male-victims-of-domestic-abuse

Recommendation	Scope - Local or National	Actions	Agency	Key Milestones Achieved in Enacting Recommendation	Target Date	Date of completion and outcome
			Interpersonal Violence (SCC)			
Develop a co-ordinated and multi-agency awareness campaign and roll out to the community and professionals regarding domestic abuse to include male victims and the impact of mental health and suicide.	Local	• SDAPB to ensure male survivors and various specialist/'By & For' services are included within any promotional material and survivor voice groups • Comms and Learning Sub-Group, working with partners, to develop a co-ordinated awareness campaign with clear messaging and language that relates to the community, using online platforms and other means to reach minoritized communities. • Somerset Domestic Abuse Strategy to consider how it will implement a Whole System Approach using models recognised across the country (Example: Safelives: Whole Picture Strategy, Coordinated Community Response) • Share best practice and examples for domestic abuse policies for	SDAPB Chair Comms and learning Group Chair SDAPB Chair Senior Commissioning Officer	Somerset has implemented the Family Safeguarding team within Children Social Care with a coordinated response to those families where there is domestic abuse, mental health and/or substance misuse. This service is for those who meet the Child Protection threshold therefore a mechanism is required for those who require early help/child in need support.	From April 2023 By April 2023 From April 2023 By April 2023	

Recommendation	Scope - Local or National	Actions	Agency	Key Milestones Achieved in Enacting Recommendation	Target Date	Date of completion and outcome
		staff and clients on Somerset Survivors website. • Mankind Initiative, SIDAS and ICS to work together to create a document on how to identify male victims of domestic abuse, the complexities of additional presentations, how to manage a disclosure and the support services available (local and nationally)	Interpersonal Violence Mankind Initiative, SIDAS Strategic Manager and ICS		From April 2023	
LSU to increase supervisory oversight of cases through audits and dip sampling to increase consistency in decisions to contact victims of domestic abuse where a crime is recorded.	Local	• LSU to ensure they have a policy and procedures including expectations of the service and responses to domestic abuse.	LSU Detective Inspector (Avon and Somerset Constabulary)		From April 2023	
Although Open Mental Health is available to find online there needs to be positive work to raise awareness in other forms ensuring those who may not have access to the internet or social media can seek	Local	• Work with partnership board Comms teams to have a coordinated awareness campaign	Open Mental Health		From April 2023	

Recommendation	Scope - Local or National	Actions	Agency	Key Milestones Achieved in Enacting Recommendation	Target Date	Date of completion and outcome
information of the support available.						
The Suicide Prevention Partnership Forum will ensure that a representative from the Domestic Abuse Partnership is invited to forum meetings which occur quarterly.	Local	• Identify and invite a representative from the Domestic Abuse Partnership. • Domestic Abuse to be a standing agenda item for sharing information	Health Improvement Manager for Public Health		October 2023	
A representative from the Domestic Abuse Partnership (alongside other professionals within the field) are to be invited to sit on the Suicide Prevention Partnership Forum working group for the High-Risk Groups workstream when they focus on domestic abuse.	Local	• The domestic abuse partnership representative to attend the working group.	Domestic Abuse Partnership		October 2023	
A member from the Somerset Suicide Prevention Partnership (Public Health or other relevant agency) is to be invited as a panel member for any future domestic	Local	• Safer Somerset Partnership to include a member from the Suicide Prevention Team on the panel attendee's list for any future domestic abuse death reviews.	Senior Commissioning Officer Interpersonal Violence (SCC)		October 2023	

Recommendation	Scope - Local or National	Actions	Agency	Key Milestones Achieved in Enacting Recommendation	Target Date	Date of completion and outcome
abuse suicide reviews within Somerset.						

b. Home Office QA Panel Feedback Letter

Home Office

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Suzanne Harris
Senior Commissioning Officer
Somerset County Council
Public Health, B3S,
County Hall, Taunton,
TA1 4DY

28 December 2023

Dear Suzanne,

Thank you for resubmitting the report (Adam) for Safer Somerset Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in December 2023.

The QA panel noted the good range of research cited, especially around the impact of COVID-19 on domestic homicides and suicides. The inclusion of independent domestic abuse representation on the panel was also welcomed. The report was praised for the condolences offered to the victim's family and friends.

The QA panel noted that most of the issues raised in the previous feedback letter following the first submission have now been addressed.

The view of the Home Office is that the DHR may now be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel