SAFER SOMERSET PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Report into the death of Angela

January 2022

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Feel Safe, Be Safe

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Author – Dr Shonagh Dillon, LLB, DCrimJ

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Glossary

BBR – Building Better Relationships

CBT – Cognitive Behavioural Therapy

CCB – Coercive and Controlling Behaviour

CCG – Clinical Commissioning Group

CFS – Chronic Fatigue Service

CPS – Crown Prosecution Service

CSC - Children's Social Care

CSP – Community Safety Partnership

DA – Domestic Abuse

DARA – Domestic Abuse Risk Assessment

DASH – Domestic Abuse, Stalking and Honour Based Violence

DHR – Domestic Homicide Review

EMDR - Eye Movement Desensitization and Reprocessing

FIS – Family Intervention Service

GP – General Practitioner

HRT – Hormone Replacement Therapy

ICB – Integrated Care Board

IDVA – Independent Domestic Violence Advocate

IMR – Independent Management Review

LSU – Local Safeguarding Unit

MARAC – Multi-Agency Risk Assessment Conference

MASH – Multi-Agency Safeguarding Hub

NCDV – National Centre for Domestic Violence

NFA – No further Action

NHS – National Health Service

NICE – National Institute for Care Excellence

NMO – Non-molestation Order

OM – Offender Manager

PIN – Police Information Notice

PLW – Partner Link Worker

PSED – Public Sector Equality Duty

QA – Quality Assurance

RO – Restraining Order

SIDAS – Somerset Integrated Domestic Abuse Service

TFA – Tech-Facilitated Abuse

VAWG – Violence Against Women and Girls

UNODC - United Nations Office on Drugs and Crime

WHO – World Health Organisation

DHR Overview Report into the death of Angela, January 2022

Preface

The independent author, DHR panel and the Safer Somerset Partnership wish to offer their deepest condolences to everyone who was affected by Angela's[1] death. We extend our further thanks to Angela's family for contributing to this review, their generosity in doing so, considering their loss, is greatly appreciated.

In addition, the author and the panel would like to extend our thanks to all professionals who responded to the Independent Management Reviews, their time and effort enabled some robust analysis and recommendations.

Finally, the author of the report would like to extend her sincerest thanks to the panel members for their professionalism and the considered manner in which they approached this review.

1. Introduction and Background

1.1 This review will examine the circumstances surrounding the death of a 48-year-old woman, Angela, who died by suicide in January 2022.

1.2 Domestic Homicide Reviews (DHRs) came into force on the 13th of April 2011.They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004).

The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by-

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

(b) A member of the same household as herself; with a view to identifying the lessons to be learnt from the death[2].

1.3 The purpose of a DHR is to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

[1] Not her real name

[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office - December 2016

b) 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.

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice

1.4 Timescales

This report of a domestic suicide examines agency involvement and responses afforded to Angela, who was a resident of the Somerset area prior to her death in January 2022.

The review will consider agency contact with Angela and her ex-partner Kevin[3] and for the period of:

Angela – 01/01/2018 to January 2022
Kevin – 01/01/2018 to January 2022
This time frame was agreed to be appropriate by all panel members in May 2022.

The referral from Somerset NHS Foundation Trust was sent to the CSP on 31st January 2022. The decision to undertake a DHR was made by Safer Somerset Partnership (CSP) on 5th March 2022. The Home Office was subsequently informed. On 6th April 2022 the CSP commissioned Dr Shonagh Dillon to undertake the role of independent author and chair to the panel and the DHR panel was convened. All meetings took place virtually. The panel members met on the following dates:

- 17th May 2022
- 26th July 2022
- 22nd November 2022
- 7th March 2023

[3] Not his real name

1.5 In Somerset, the Safer Somerset Partnership perform the statutory duties of the community safety partnership. The overview report and executive summary were approved by the Safer Somerset Partnership Chair on 29 May 2023 and submitted to the Home Office on 30th May 2023 The report was considered by the Home Office Quality Assurance Panel in December 2023 and approved for publication.

1.6 Somerset takes the issue of domestic abuse seriously; the county has an exemplary record of prioritising and commissioning innovative services for victims and survivors of domestic abuse.

Somerset County Council has commissioned specialist domestic abuse services for victims and perpetrators since 2005, and since 2015 has commissioned an integrated domestic abuse service for victims plus support for their children and work with perpetrators. Its strategic approach includes these principles:

- ✓ Take a public health approach – focus on prevention.
- ✓ Domestic abuse doesn't discriminate – so services and options for safe accommodation must be accessible for all who need it.
- ✓ Children are victims too; the system must be able to respond to identify young victims and provide them with the right support.
- ✓ We will work together as agencies and with communities to make Somerset a safe place for victims and families.

1.7 People involved in the DHR:

Name	**Age at time of death**	**Status**	**Ethnicity**
Angela	48	Victim	White British
Kevin	45	Ex-partner and perpetrator	White British

Angela had three children with Kevin.

The panel has applied the Home Office guidance and has given the pseudonyms identified above to the offender and the victim. The family were happy with the name given to Angela, they said she loved angels and would have liked the name.

It is hoped the pseudonyms humanise the review process and eases the reading of the report.

1.8 Tribute

Angela's family shared a few words about who she was:

> *Angela was very artistic, she loved going to art exhibitions. Once a year she spent a weekend working at the Bath Art Fair and usually spent her earnings at the end of it by buying some pictures she fell in love with! She was amazing at growing orchids (in fact her last sight before she died was of about*

20 orchids in bloom). She loved her sustainable garden and loved finding new places to visit. Every year we would meet at Angela's house on Christmas eve for a buffet and she would pick a church for us to attend for the Nativity Service. The best featured a donkey, who did what donkeys do and gave a realistic smell of the stable in Bethlehem! She had many friends who filled different needs in her life, from sustainable festivals, foraging, art, to dog walking, they all miss her so much. She was like an agony aunt always listening to their problems and giving advice. Her children were the biggest loves of her life. She was a lioness where they were concerned getting help with the children's needs, when there was little help being offered. She was so proud of their achievements. We all miss her very much.

The family also wished for this poem to be represented in the review as a tribute to Angela:

"She was beautiful, but not like those girls in magazines.

She was beautiful, for the way she thought.

She was beautiful, for the sparkle in her eyes when she talked about something she loved.

She was beautiful, for her ability to make other people smile, even if she was sad.

No, she wasn't beautiful for something as temporary as her looks. She was beautiful, deep down to her soul. She is beautiful." F. Scott Fitzgerald

1.9 Summary

Angela and Kevin were in a relationship for 17 years and had three children together. They moved from London to Somerset in 2003 and set up home with their first son. They subsequently had two more children another son and a daughter. All three children have an official diagnosis relating to neurodivergence.

Angela became pregnant within one month of her and Kevin meeting and from the outset Angela's family noted that Kevin was controlling. When talking to the chair of the panel, the family relayed an incident a friend of Angela's had recalled early on in Angela and Kevin's relationship. Kevin had come into the living room whilst they were chatting one day, he had barely spoken to Angela's friend and Angela explained this was just how he was. Angela and her friend popped out of the house and when they came back Kevin had cut the wire to the Television to stop them from watching it.

Life was difficult for Angela, she had three small children with the compounding factors of coping with neurodivergence. Kevin continued to show abusive traits throughout the relationship and Angela often wondered if he was neurodivergent or had mental health issues. Angela expressed to her family that she really wanted to make things work with Kevin, but his behaviour became progressively more violent and controlling.

In 2018 Angela began to seek help from external agencies for the domestic abuse she was experiencing, at this stage she still wanted things to work between her and Kevin, but escalating events led her to leave Kevin in late 2018. Throughout the following years until her death Kevin continued to be abusive towards Angela, resulting in four convictions for physical assault, and Kevin continued a course of persistent stalking and harassment throughout. Angela's sister explained to the review author that Angela was incredibly proud that she never returned to Kevin after leaving him. Although life was a struggle every day, Angela knew that Kevin was abusive.

From the detail below we can see that Angela was very proactive in seeking support from various different agencies in relation to the domestic abuse. But Kevin continued his behaviour and Angela's stresses were exacerbated by financial issues and being a single Mother to three children with special needs.

In January 2022 Angela died by suicide, may she rest in peace.

It is the view of the panel, the chair, and most importantly Angela's family, that her life is honoured within this review, so that lessons can be learned, and Angela's experience of the system and organisations, can lead to change for other victims of domestic abuse.

2. Parallel Reviews and Processes

2.1 The Coroner's inquest was concluded in March 2022 and Angela's death was noted as suicide.

2.2 There were no other parallel review processes arising from Angela's death.

3. Domestic Homicide Review Panel

The DHR panel consisted of the following agencies and professionals:

Job Title/ Agency	**Name**
Independent Chair and Author	Dr Shonagh Dillon
Senior Commissioning Officer (Interpersonal Violence) Somerset County Council	Suzanne Harris
Domestic Abuse Expert (Paragon Regional Manager)	Jayne Hardy
Named Professional for Safeguarding Adults / Prevent Lead	Heather Sparks
Designated Nurse for Safeguarding Adults	Julia Mason

NHS Somerset Safeguarding Team	
Detective Inspector Major Statutory Crime Review Team	Su Parker
Head of Service, Probation Service Somerset	Liz Spencer
Operations Manager First Response, Early Help Hub and EDT (Children's Social Care)	Kelly Brewer

4. Independence

4.1 The author of this report, Dr Shonagh Dillon, was independent of all agencies involved in the panel. She had no previous dealings with the initial inquiries and no contact or knowledge of the family members.

Dr Dillon is a Home Office accredited DHR chair and has nearly three decades of professional experience in the male violence against women sector supporting victims and survivors of domestic abuse, sexual violence, and stalking.

All IMR authors and Panel members were independent of any direct contact with the subjects of this DHR. None of the panel members were the immediate line managers of anyone who engaged with Angela or Kevin.

5. Terms of Reference

5.1 The full terms of reference, which were agreed at the first panel meeting and are included in Appendix A of this report.

5.2 The specific aims of the review were identified as follows:

- 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 learned from the case about the way in which local professionals and agencies worked together to support or manage the person who caused harm.

6. Confidentiality and Dissemination

6.1 Whilst it is essential to share key issues with agencies and organisations involved in this DHR, this report will not be disseminated until clearance has been received from the Home Office quality assurance group.

The IMRs will not be published but the DHR report will be made public.

The contents of this report are anonymised to protect the identity of the deceased, family, friends, staff, and others to comply with the Data Protection Act 2018[4].

Once clearance has been approved by the Home Office quality assurance group, the dissemination of the overview report will be published on the Somerset Survivors website and will be widely disseminated including, but not limited to:

- Members of the Community Safety Partnership
- Somerset Domestic Abuse Board
- Avon and Somerset Police and Crime Commissioner
- Domestic Abuse Commissioner for England and Wales
- Somerset Safeguarding Children Partnership
- Somerset Safeguarding Adults Board

6.2 The Somerset Domestic Abuse Board will be responsible for monitoring the implementation of recommendations.

7. Methodology

7.1 Following the decision to conduct the DHR, Avon and Somerset Police provided the panel with a timeline of the case. Subsequently, several other statutory and voluntary sector agencies were asked to return a summary of their involvement to help the panel analyse any interactions they had with Angela and Kevin during the specified review period.

Having considered the summaries, the following Individual Management Reviews (IMRs) were requested:

[4] https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted

a) Avon and Somerset Police
b) Somerset NHS Foundation Trust
c) Children's Social Care
d) National Probation
e) Somerset Independent Domestic Abuse Service (SIDAS)
f) Education
g) Somerset ICB

7.2 The Terms of Reference guidance set out the purpose and the scope of the review and the panel focused specific questions to each agency whilst undertaking the analysis of their involvement. The scope for IMRs were as follows:

- 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 victim or her family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
    - Against the Equality Act 2010's protected characteristics.
    - In regard to children and pregnancy and any potential impact this had ensuring the safeguarding of any children during the review.
- 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. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

- Examine the events leading up to the incident, including a chronology of the events in question.

  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.

The authors of the IMRs are independent in accordance with the Home Office guidance[5].

7.3 This report is based on:

- The combined chronology of all agencies
- The findings of the IMRs
- Further requested information and analysis resulting from the IMRs and discussions at panel meetings
- The views of Angela's family

A descriptive analysis of the combined chronology from Angela's perspective is set out in section 9 of this report.

The IMRs are represented in section 10; IMR author's offered single agency recommendations combined with the panel's multi-agency and national recommendations, which are presented in section 14 of the report.

The conclusions and recommendations are the collective views of the Panel, which has the responsibility, through the participating agencies, for implementation of any improvement recommendations.

8. Involvement of Family and Friends

8.1 Angela

The chair of the panel initially wrote to Angela's family members in July 2022 – despite their distress at their loss - Angela's parents were incredibly gracious in contacting the

5 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf (Section 7)

chair, who they initially met via video link in August of 2022. The Chair and Angela's Mother continued to communicate via email over the course of the review.

The decision was made following discussions with Angela's family not to meet with her children. Angela's family felt that being involved in the review at this stage in the children's lives would be incredibly stressful for them. It was agreed with the family that the review author would send the published report to them so that, should the children wish to read the contents of the review in the future, they could do so with family support.

Just prior to the end of the review process, Angela's sister contacted the chair, and they met in March 2023. Angela's sister's thoughts were concurrent with the panel's findings and her response is reflected in section 11.9. Angela's sister was also sent a copy of the final draft of the review in order that she, and her other sibling, could add her comments. In addition, she expressed a desire to be involved in supporting the panel recommendation of representing Angela's story in a webinar/training for multi-agency professional (see 14.1). Angela's sister kindly offered to add her voice to this webinar so that professionals can understand better how to support victims of domestic abuse.

The chair of the review and all panel members are immensely grateful for the time and attention Angela's family gave to the review process. Their contribution ensured the review was robust, and that Angela's voice was not lost.

8.2 Kevin

The panel deliberated on whether to contact Kevin as part of this review. The panel undertook a full risk assessment with the intelligence that was available to them and decided against contacting Kevin. This was in part due to his history of not taking responsibility for his behaviour towards Angela.

The panel also had intelligence to suggest that Kevin was in a new relationship. All safeguards were monitored and actioned towards his current partner, and the panel wanted to mitigate any further risk towards her by preventing any contact with the review author so as not to instigate any further abuse.

After speaking with Angela's sister, the review author confirmed that the panel had made the correct decision in not contacting Kevin. Angela's family continue to safeguard the children to ensure they are not affected any further by the loss of their mother and their father's abusive behaviour.

The report is therefore limited in the response and thoughts of the perpetrator in this case.

9. Descriptive Chronology

9.1 The lead for DHR's in Somerset was able to combine the chronology templates from all organisations into one document. This was an incredibly useful exercise in

enabling the author to analyse the incidents in one place and it is not something that the author of this report had received before when undertaking previous reviews. A recommendation for all local authorities to provide this depth of information in such an accessible format will be listed in the national recommendations at the end of this report. Although the Home Office Quality Assurance Panel (see appendix B) noted combined chronologies to be standard practice, the review author had previously completed four other DHRs across the country and this is the first time she had received a combined chronology. Therefore, a reminder to local authorities to meet this expected standard will remain within the report.

The chronology combines the listed contacts and incidents from the timeline requested of 01/01/2018 to January 2022. Having analysed the combined chronology in its entirety the author of this report felt it should be used as an example of what was going on for Angela over the timeline.

The author has removed any information in relation to Kevin or the children and represented the chronology incidents in relation to Angela alone. This is presented in a diary type format from Angela's perspective. Some of the detail on what happened in the background with separate agencies referrals and information sharing has been removed to represent the description from Angela's perspective.

A full description of agencies perspectives will be presented within the IMR's (section 10), where a more detailed scrutiny of analysis is applicable. Angela would have been unaware of the processes behind the scenes; therefore, the descriptive analysis below is used to give an idea of what navigating support and managing contacts with different agencies was like for Angela whilst she was being subjected to long term and persistent domestic abuse and stalking behaviours from Kevin.

Further incidents from the combined chronology which relate to Kevin and the children will be presented in the IMR section and analysis sections 10 and 11.

9.2 June 2018

9.2.1 On 25/06/2018 Angela referred herself to the Somerset Independent Domestic Abuse Service (SIDAS). She was asked to complete the Domestic Abuse Stalking and Harassment[6] (DASH):

> *DASH is a risk multi agency risk assessment tool, designed to manage risk for victims and co-ordinate safety plans and services. A DASH is completed by a professional who asks the victims a list of between 24 or 27 questions, the information given by the victim is then used to assess the risk the perpetrator presents to the victim and facilitate a safety plan for the to safeguard against further abuse and violence.*

6 https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf

Angela was assessed as medium risk of domestic abuse from Kevin. This is the first recorded DASH risk assessment within the chronology report. The case was transferred for allocation, but Angela did not receive a follow up call from SIDAS.

9.2.2 Four days later, 29/06/2018, Angela had a face-to-face appointment with her GP where she disclosed that she was being subjected to domestic abuse from her husband, Kevin. She was risk assessed for the second time and the DASH completed by the GP assessed her as medium risk.

A referral was sent to children's social care. The GP noted that Angela disclosed Kevin was checking her underwear and accusing her of having an affair, he had made unpleasant comments on Facebook, and was spitting at her and smashing things up in the garden.

Angela described her financial worries and said that she was facing bankruptcy, she told the GP that she had contacted the domestic abuse helpline four days earlier and had completed a questionnaire – we can assume this was the DASH listed on 25/06/2018.

The GP did some basic but robust safety planning with Angela. Angela said she would go to her sisters or her parents if she needed to flee in an emergency.

9.3 July 2018

9.3.1 In July on 06/07/2018 Angela called the GP back as she was worried about the children's safeguarding referral. The GP describes Angela as 'very nervous', Angela was worried that social care would come into the situation as a *'blunt instrument'*, and she had wanted to see if she could *'sort it out herself'*. The GP reassured Angela of social services role, and she agreed to the referral.

9.3.2 11/07/2018 The social care referral was received; a contact was attempted for Angela but there was no response. The referral was assessed, and no further action (NFA) was decided as the case did not meet the threshold for social care intervention. The rationale for the NFA was that Kevin was getting mental health support and Angela was accessing support, this decision is in line with the duty of care for Children's Social Care.

9.4 August 2018

9.4.1 On 03/08/2018 Angela called SIDAS as she hadn't heard anything from them (see 25/06/2018). Her case had not been allocated. There had been a 26-day delay from her first self-referral to Angela pro-actively calling for help again.

9.4.2 The case was then transferred for support. After 4 attempted calls and one text Angela was subsequently closed to the service on 03/09/2018, this was one month after her second pro-active contact.

9.4.3 During the rest of 2018 Angela received no support or contacts from SIDAS.

9.5 October 2018

9.5.1 During October 2018 Angela sought support from her GP for menopause symptoms. She had low mood, hot flushing and wasn't sleeping well. After some discussion with her GP, she began Hormone Replacement Therapy (HRT).

9.6 November 2018

9.6.1 On 05/11/2018 Angela self-referred to counselling and started 8 sessions of therapy. The reason for the self-referral was because of the domestic abuse she was experiencing.

9.6.2 In November Angela continued to seek support from her GP around her menopause symptoms, at the time she reported, mood swings, low mood, headaches, being tearful, poor concentration and joint aches. Her GP prescribed a higher dose of HRT.

9.7 December 2018

9.7.1 In December Angela sought support again from her GP regarding the menopause. The options were discussed with Angela including prescribing anti-depressants.

9.8 Jan 2019

9.8.1 In January of 2019 on 10/01/2019 Angela called 999. Kevin had pulled her hair and had physically assaulted her in an argument about separating. The police were on the scene within fifteen minutes, where they arrested Kevin, and when in custody he admitted the offence. Initially Kevin was given an out of court disposal and was expected to attend a Cautioning and Relationship Abuse[7] (CARA). The records show that Kevin left part way through the second session and the facilitator expressed concerns for his demeaner and presentation. Due to the fact that Angela disclosed further abuse in Feb (see below), a conditional caution was no longer appropriate. Therefore, Kevin was charged and subsequently pleaded guilty to assault by beating. He was given a fine, community order, victim surcharge, and a rehabilitation activity order. Angela was required to complete her third listed DASH form on the chronology and her risk level on this occasion was assessed as Medium.

9.8.2 Angela agreed to a referral to SIDAS, and this was sent on 11/01/2019 – Angela's number was the same as the number given to SIDAS on the 2018 referral.

9.8.3 By 14/01/2019 Angela still hadn't heard from SIDAS, so she called them again and explained that she had made several attempts to get support from them before (see 9.2 and 9.4), but never received any. She told the duty worker that she *'felt down'* and stated that Kevin was still living in the property until he finds somewhere else. Angela said she was interested in getting support from the SIDAS domestic abuse group programme, Overcoming Abuse.

The duty worker gave some safety advice, and her case was allocated to a support worker.

[7] https://hamptontrust.org.uk/program/cara/

9.8.4 *Attempts at phone contact made by SIDAS:

16/01/2019

17/01/2019

21/01/2019

The allocated worker attempted to get colleagues to pick up a call to Angela whilst she was on leave, but the process within the SIDAS system at the time would not allow for the allocations team to book calls, whilst a caseworker was on leave.

The next attempt at contact to Angela was on 31/01/2019 – this was also unsuccessful.

9.9 Feb 2019

9.9.1 On 08/02/2019 Angela made a 999 call to police this was a verbal argument with Kevin, and he was refusing to leave. Kevin did leave the property whilst Angela was on the phone to the police, but she said she was scared he would return. This incident was filed, and no further police action was taken. Police stated that 'no offences occurred'. Angela's address was flagged, and she was assisted with some target hardening of the property.

A fourth DASH was undertaken with Angela and her risk score was medium.

9.9.2 Three days later on 11/02/2019 Angela's case file was closed to SIDAS – they informed 'Lighthouse' which is the Local Safeguarding Unit (LSU) for Avon and Somerset Constabulary. (See section 10.1.5 for description of LSU and Multi-Agency Safeguarding Hub (MASH) process in Somerset)

9.9.3 The Lighthouse team contacted SIDAS on the 21/02/2019 on behalf of Angela who said she hadn't heard from them, they asked for her to be called again. SIDAS reported that Angela had been closed for *'non-engagement'*.

9.9.4 After some liaison between the LSU and SIDAS the case was re-opened five days later by SIDAS on 26/02/2019.

9.9.5 On the same day (26/02/2019) SIDAS contacted Angela – there was a note on system to say the call was successfully connected on the landline number which had previously been recorded as failed attempts. The worker from SIDAS noted there may be a possible 'bug' on the phone put there by Kevin.

9.9.6 Angela completed her fifth DASH, this time with SIDAS, and they assessed her as High risk. During this call Angela disclosed for the first time the sexual violence she was being subjected to by Kevin. Angela also described excessive coercive and controlling behaviours (CCB), including financial abuse where Kevin changes online banking information and fraudulently claims different income streams to make things difficult for her. Angela also described how Kevin used manipulation of her parenting skills as her children are neurodivergent. Kevin also publicly referred to her menopause symptoms to shame Angela, (Angela's sister later explained to the author of the review that Kevin would accuse Angela of being on drugs, because she took HRT medication).

Kevin constantly came into the property without consent and on another occasion, he broke into Angela's friend's house to abuse her. Angela described again how Kevin constantly accused her of having affairs, with both men and women. Kevin also threatened suicide as a means to manipulate her.

Angela describes how one minute Kevin would be nice to her and the next he was angry. Kevin locked her out of online accounts, hacked her Facebook account and constantly harassed her via text, he had also recently "fixed" two iPads used by the children. There was discussion around possible tracker on the car and checking the iPads. This is the first mention of stalking behaviours taking place from Kevin.

Angela talked to the SIDAS worker about wanting a non-molestation order.

9.9.7 As a result of being assessed as at High-risk of domestic abuse from Kevin, Angela is referred to the Multi-Agency Risk Assessment Conference (MARAC) and to the Independent Domestic Violence Advocate (IDVA) service.

9.10 March 2019

9.10.1 Six days after speaking with SIDAS on the 04/03/2019 Angela made a 101 call to the police for stalking and harassment. She said Kevin was tracking her and turned up at her address if she didn't answer his emails promptly. Angela tells the police she doesn't want any formal action but would like for the police to talk to Kevin. The police gave Kevin 'words of advice', listed the incident as stalking and harassment, and applied a decision of NFA.

9.10.2 On this occasion Angela completed her sixth DASH, which was assessed as Medium. It is noteworthy that six days earlier on 26/02/2019 the SIDAS DASH had assessed her as High Risk.

9.10.3 A Day later on 05/03/2019 SIDAS made a call to Angela. Angela described how she felt *'overwhelmed and anxious'* and that Kevin seemed to know where she was all the time; Angela gave examples of Kevin telling her he knew she was at the cinema with a friend. Kevin constantly changed times and arrangements for when he was meant to have the children and this was very unsettling for them, especially given their additional needs. There was no mention of whether Angela disclosed she had called the police the previous day or whether the SIDAS worker asked her about reports to the police, or any other agencies.

SIDAS gave Angela advice on civil orders and legal aid. The SIDAS worker gave advice on disabling location markers on her phone and Facebook. Target hardening was noted to have been done at Angela's property.

Angela was told by SIDAS *to 'keep boundaries regarding face-to-face contact and wishes regarding the relationship'*.

9.10.4 Five days later on 10/03/2019 Angela made a 999 call to police at 00:43 in the morning. Angela reported Kevin at the property, and they were arguing. On attendance Kevin was hostile to the police. Angela stated she was getting support from SIDAS and had asked her family to come over. The police listed this as an NFA and filed it stating, 'No offences occurred' as it was a 'verbal argument'.

Angela was asked to complete her seventh DASH form and the risk from Kevin to her on this occasion was assessed as standard.

9.10.5 The same day 10/03/2019 – 11:53 in the morning Angela made another 999 call to the police. Kevin was trying to break into the property, had thrown a 'big metal planter', and made threats to kill himself. Angela subsequently attended the police station to talk to officers. She was given details of how to get a non-molestation order and resetting and changing her devices in case Kevin was tracking her. The police did a welfare check on Kevin, due to the threats of suicide and 'words of advice' were given to him about attending Angela's address. The case was filed and listed as NFA.

At the police station Angela completed her eighth DASH and was assessed to be at medium risk from Kevin.

9.10.6 NB: Angela had undertaken two DASH forms in the space of ten hours. The DASH assessments undertaken on 10/03/2019 were 6 days after previous police DASH which assessed Angela as medium and 12 days after the SIDAS DASH which assessed her as High Risk.

Within 12 days - the risk that Kevin posed to Angela - had been assessed as ranging from High, to medium, to standard, then subsequently to medium risk.

9.10.7 Eight days later on 18/03/2019 Angela called 101 reporting a verbal argument that resulted in Kevin physically attacking her including kissing her against her will. The assault was witnessed by their daughter. The police later charged Kevin with assault by beating and he was given a community order. Whilst Kevin was waiting for his court appearance, he was made the subject of bail conditions.

Police completed Angela's ninth DASH form and assessed her as medium risk.

9.10.8 The same day on 18/03/2019, Angela called SIDAS giving them a new number as Kevin had taken her phone. The allocations team from SIDAS asked the support worker to contact her.

On 21/03/2019 there was already correspondence in the SIDAS notes of the intention to close Angela's case. The new number Angela had given SIDAS was not called until 10/04/2019 (nearly one month later see 9.11.2).

9.10.9 Following up on the physical assault from Kevin, Angela attended Minor Injuries Unit (MIU) on 18/03/2019. Angela disclosed the domestic abuse she was experiencing with the staff at the MIU, and she understandably presented as 'upset'. Angela was treated for tissue injury to left cheek, upper arm, left forearm, and wrist.

9.11 April 2019

9.11.1 Just under three weeks later on 07/04/2019, Angela called 101 reporting a verbally abusive call from Kevin regarding child contact. Angela undertook her tenth DASH which was assessed as medium risk. The police reported that no offences were confirmed, and they took no further action (NFA).

9.11.2 On 10/04/2019 SIDAS called Angela on her new number. This was over three weeks after Angela had shared her number with SIDAS. She disclosed that Kevin was

refusing to pay anything towards the bills or mortgage. Angela also explained how only their eldest son was having contact with Kevin and this was causing issues, as her eldest child was displaying concerning behaviours that mimicked Kevin. Kevin had filed for divorce stating Angela's unreasonable behaviour. A non-molestation order was discussed, and Angela was advised to take paperwork to a solicitor.

9.11.3 NB: The author of the report spoke at length to Angela's parents and her sister, and they explained that she undertook all the divorce and family court legal proceedings herself with no financial support, little guidance, and no legal representative.

9.11.4 Twelve days after her previous police report on 19/04/2019, Angela called 101 again. Kevin had come to her address when she was out and let himself in, scaring the children. He went through the post and took some items, then returned later with some gifts for the children. The police took no NFA for this incident, stating 'no offences committed'.

9.11.5 Angela completed her eleventh DASH form, and this was assessed by the police as standard risk. This is 12 days after the risk was assessed by the police as medium.

On the 24/04/2019 – SIDAS called and left Angela a message.

9.12 May 2019

9.12.1 On 01/05/2019 Angela called 999. Kevin had somehow got her new number and was sending offensive messages via phone suggesting he knew what she was doing *'all the time'*. The case was investigated and submitted to the Crown Prosecution Service for a charge of malicious communications.

There were now several concurrent investigations in relation to Kevin's abuse of Angela. Angela told the police that she had already spent five hours giving a statement to another officer, she was asked to give another statement for this incident and 47 pages of emails were sent in evidence to the Crown Prosecution Service (CPS). Subsequently the CPS continued with the case of assault which occurred on 29/06/2019 but dropped the charges in relation to malicious communications.

Angela completed another DASH, this was her twelfth, the police assessed her as at high risk from Kevin. This was thirteen days after the risk being assessed as standard.

9.12.2 On the same day (01/05/2019), SIDAS called Angela. She disclosed that further incidents had occurred and that she had reported them to the police. Angela also explained how Kevin had withdrawn all financial support and her home phone and internet had been cut off. SIDAS referred Angela to the National Centre for Domestic Violence (NCDV) for an application to get a non-molestation order. Angela asked SIDAS again about the Overcoming Abuse course that SIDAS operate, but SIDAS were not taking referrals for this course at the time.

9.12.3 Four days later on 05/05/2019 Angela called 101 as she was worried her handbag had been stolen by Kevin. She later called back to say she found it.

9.12.4 A Day later on 06/05/2019 Angela called 101 reporting an incident that resulted in Kevin assaulting Angela when he pushed her head against the car window with his head and kicked her car as she drove away. Angela's daughter was a witness to this assault and provided a statement. Kevin was charged and found guilty of common assault and ordered to do unpaid work and perpetrator programme with probation, a restraining order was applied by the court.

A thirteenth DASH was completed with Angela and assessed by the police as High Risk.

9.12.5 On 14/05/2019, Angela spoke to SIDAS. Angela disclosed all the further incidents she had reported to the police. She stated she was still waiting for NCDV, this was two weeks after the referral. *NB: A non-molestation order is meant to be an emergency response*. SIDAS advised Angela to represent herself at court to *'save time'*. Angela explained she was waiting for charging decisions on criminal damage, assault, and harassment against her.

9.12.6 On 17/05/2019 SIDAS made a call to Angela after speaking to the school. SIDAS asked how Angela was progressing with the non-molestation order. Angela explained that she had left a voicemail and an email for NCDV but had no response.

9.12.7 Three days later on 20/05/2019 Angela was called by Children's social care after report from police to them for high-risk domestic abuse. At that time there was three criminal court cases pending for Kevin. Angela explained to the social worker that she was working with SIDAS and getting all the right support as well as trying to get a non-molestation order. There was a note on the children's social care file that stated Kevin was not contacted as police noted he does not take responsibility for his behaviour and the social worker did not want to exacerbate the situation for Angela by contacting Kevin.

9.12.8 Social care also noted that there had been 14 calls to police in last 5 ½ months, but not all had resulted in referrals from police to social care (see IMR section 10.4 for further info)

9.12.9 The same day (20/05/2019) Angela self-referred to counselling services because of the ongoing physical, psychological, and financial abuse she was being subjected to from Kevin.

9.12.10 Three days later on the 23/05/2019 the counselling service spoke to the SIDAS IDVA, the counselling assessment stated that the impending court case meant Angela was not suitable for Cognitive Behavioural Therapy (CBT), and she was discharged from the service. Details were given to Angela on how to contact a support group for victims of domestic abuse.

9.13 June 2019

9.13.1 Unbeknownst to Angela on 13/06/2019 the SIDAS IDVA closed her case. The exit form stated there were no further IDVA actions to complete. The rationale for closure was 'Client resuming criminal charges and will apply for a restraining order'.

NB: Victims cannot get restraining orders, these are applied for by the police, and, or counsel at criminal court, so we can only assume that the SIDAS IDVA meant that Angela was trying to get a non-molestation order (NMO). SIDAS previously noted that Angela was struggling to get an NMO. In addition to this the pursuance of criminal charges and her help seeking activities would increase the risk to Angela from Kevin[8].

Angela had been open to SIDAS for 6 months at this stage, she had 9 contacts with the service as a whole and two of these contacts were initiated by her. She was referred to the Overcoming Abuse course by the IDVA when the case was closed. Although there were a series of attempts at contact with Angela (see IMR section 10.6) the review author will query the rationale and reason in closing Angela to domestic abuse support in the analysis section.

9.13.2 On the 22/06/2019 Angela called 101. She reported that Kevin had been following her in her car and then drove into it after beeping the horn at her. The police attended Angela's address three days later and applied an NFA to this incident stating there had been 'no damage to the car', therefore 'no offences' had occurred.

No DASH risk assessment was completed with Angela on this occurrence.

9.13.3 On the 28/06/2019, Angela called 101 after being subjected to verbal abuse from Kevin. Angela reported that Kevin had tried to take some paperwork when he was last at the property, and she explained to the police that she needed offences recorded for the family court proceedings. The police determined that Kevin's language had been 'argumentative but not threatening' and she was given safety advice. The case was filed with NFA.

Angela undertook a fourteenth DASH for this incident and the police assessed her as High Risk.

9.13.4 A Day later on the 29/06/2019, Angela dialled 999 after Kevin had come to the property and been verbally abusive then tipped her out of a chair. Angela had filmed this. Kevin was arrested and charged for common assault.

9.13.5 Bail conditions were applied whilst waiting for the court case. In December of 2019 Kevin admitted guilt and was given a community order and a restraining order was applied against Kevin for protection from harassment of Angela.

During this incident Angela was asked to complete her fifteenth DASH form (a day after her previous DASH). She was assessed as High Risk by the police.

9.13.6 The police completed onward referrals to IDVA/MARAC and Childrens social care. As noted by CSC this was one month after the reported incident.

9.14 July 2019

9.14.1 Three days later on 01/07/2019 Angela called 999 again stating that Kevin had hacked her Facebook account after she had put something onto her status about the abuse she had been experiencing. He then sent messages to other people pretending

[8] https://safelives.org.uk/sites/default/files/resources/Getting%20it%20right%20first%20time%20-%20complete%20report.pdf

to be her. This incident was filed with NFA. The notes state that it was a *'domestic incident with no offences*'. An officer advised Angela to close her Facebook account and stated that she *'refused to do this'*.

Angela undertook her sixteenth DASH after this incident and was assessed to be High Risk by police.

9.14.2 On 24/07/2019 SIDAS received an IDVA referral for the physical incident on 29/06/2019 (one month delay in police incident and six weeks after the IDVA had closed Angela's file). The referral states that Angela disclosed that Kevin is 'completely out of control and 'will not leave her alone'.

There was a note on the SIDAS system from the Team Manager at SIDAS with the internal referral to the IDVA stating: 'can you call her and do some safety planning…I don't think this will be open for long'.

9.15 August 2019

9.15.1 Seven days later on 01/08/2019 the IDVA from SIDAS made a call to Angela. Safety planning was done with Angela and another referral made to Overcoming Abuse course.

The SIDAS IDVA asked Angela to complete her seventeenth DASH and assessed that her risk was downgraded to medium.

9.15.2 On the 09/08/2019 Angela made a 101 call to the police to report the hacking of her Facebook account – Kevin was sending nasty message accessing her email account and deleting messages that she needed for family court. This was a report that was linked to the previous one on 01/07/2019. Police again noted that Angela had already been told to close her Facebook account down and *'refused to do this'*. The case had already been filed with 'no offences committed'.

9.15.3 Angela was keen to ask whether this breached the restraining order against Kevin. But the police stated she was unclear about the bail conditions believing them to be a restraining order (RO). The incident was filed again and NFA was applied. Police stated no breach of bail had occurred.

NB: Angela completed her eighteenth DASH and was assessed as Standard risk. (In the last 16 days Angela had been risk assessed three times and all the assessments rate her risk differently. She has gone from High, to medium, to standard.)

9.15.4 On 15/08/2019 Angela called 101 reporting that she has been receiving emails all morning from Kevin about the children going abroad. Saying he will report her for child abduction. She also reported that Kevin had hacked her Facebook account and accessed her online banking. The police cross referenced this report to the previous allegation on 09/08/2019 and no new offences had been reported by Angela. The previous report had been filed as NFA and this report was allocated the same decision.

For this incident Angela completed her nineteenth DASH form and she was assessed as standard risk.

9.15.5 On 16/08/2019 Angela received a call from SIDAS. They gave her advice around the family court case and Kevin's claiming child abduction due to her allowing the children to go on holiday. Angela noted she was still waiting for charging decisions on previous reports to the police.

9.15.6 On 20/08/2019 Angela's case was rejected from the MARAC list; the rationale was that she had sufficient support through the IDVA service.

Three days later on the 23/08/2019 the IDVA closed Angela's case for the second time in two months. This second closure was 23 days after her case had been opened. She had received two contacts from the IDVA during the 23 days. The IDVA referred Angela to the Overcoming Abuse course for the third time.

It would then be a further 3 months before the course started and 11 months since Angela first asked to be placed on the course.

9.16 November 2019

9.16.1 There is a three-month gap where no agencies had any contact with Angela. On the 01/11/2019 she had a GP appointment where she discussed the domestic abuse. She described how she had low mood and had stopped taking HRT. Angela wanted to try an alternative to HRT.

Angela expressed that she was keen to access counselling again, and the GP suggested she self-refer back to Talking therapies.

9.17 December 2019

9.17.1 On 15/12/2019 Angela called 101 as she had *'bumped into'* Kevin whilst in a local town. Angela was worried he may have been following her and this was a breach of the restraining order which had been issued on 05/12/2019. Police determined that it was reasonable he may be in the same place as her, given it was close to where they both lived and took no action. No DASH form was completed with Angela on this occurrence.

9.18 January 2020

9.18.1 In January on the 03/01/2020 Angela called 101 again and repeated the reported the breach of Kevin in the local town. Angela also explained that at Christmas Kevin had sent home a 'present' for her with one of their children – the present contained her old passport, a t-shirt and as a regifted present. Angela expressed that she felt *'things were escalating'*.

Police listed this as another NFA and stated no breaches had occurred. They spoke to Kevin who said he didn't know of the RO, but knew he had bail conditions, he denied following her.

Angela completed her twentieth DASH form, which was assessed this time to be standard by the police.

9.18.2 On the 06/01/2020 SIDAS contacted Angela to let her know about the Overcoming Abuse group, which was starting in three days. Angela was upset that

she hadn't been contacted sooner and had to shift things around at such short notice. She had been waiting for the course for 11 months.

Angela explained via text:

> *'I have had to support myself through this and would really prefer to know in advance so you can make sure you can make it…knowing it is on is actually a basic requirement and I hope that other women aren't in the same boat.'*

The SIDAS worker offered to feed it back to management and Angela was happy with this stating:

> *'Just great to get the info across as important that women are able to access and get support and this approach seems invalidating and not mindful of the people that are being assisted. Thanks for feeding it back.'*

9.18.3 On the 09/01/2020 Angela attended the group session, and she again expressed frustration at how she had been given short notice and not kept up to date about group start. The notes state that she was a very positive member at group.

9.18.4 On the 16/01/2020 the SIDAS notes evidence that Angela attended group and shared a lot with the other women. The notes also state that she got on well with the other women.

9.18.5 On the 19/01/2020 Angela called 101 to report Kevin had parked near their house, she said this was a breach of RO. The police took no further action. The officer stated that it was reasonable for Kevin to park there to pick up their child. The police also noted that the incorrect address had been placed on the RO, therefore they couldn't have actioned the RO anyway. Angela said she had asked for this to be changed.

On this occasion Angela was referred to the IDVA service again. The IDVA service rejected the referral and decided not to contact Angela their rationale being that she was *'fully aware of support services having accessed them before'*.

Angela undertook her twenty first DASH assessment after reporting this incident and was listed as medium risk.

9.18.6 On the 23/01/2020 Angela attended group; the notes say that she engaged well. There is mention of the IDVA referral that SIDAS rejected for Angela and the group facilitator noted that Angela had not told the group about the breach of the RO she had reported four days earlier.

9.18.7 On the 30/01/2020 Angela attended group again and talked about the impact the domestic abuse was having on her children and how her oldest child was now displaying aggressive behaviour within the family home, she felt her eldest was mimicking Kevin's behaviour (see section 11.8 Children for further analysis).

9.19 February 2020

9.19.1 In February 2020 Angela attended group on both 06/02/2020 and 13/02/2020.

At group Angela expressed concerns to SIDAS worker about issues she was having with the Getset worker from social care. She was very tearful and expressed how she had been told to attend a meeting and how this would be difficult as all the children were at home due to school holidays. Angela felt anxious and described issues working with Getset.

Advocacy was undertaken between SIDAS and Getset workers and this initiated a call between Angela and the Getset worker, which appeared to resolve the issue.

9.19.2 Subsequently Angela asked if someone from SIDAS could go to the children's social care meetings with her stating there were:

> *'lots of professionals and me, it is getting really impersonal, and I really don't want to go!'*

There is no account of anyone from SIDAS attending any meetings with Angela and no rationale as to why this did not happen.

9.19.3 On the 20/02/2020 Angela attended the set group session with SIDAS.

9.20 March 2020

9.20.1 The following week on 02/03/2020 Angela let SIDAS know she couldn't attend group as she was in court that week for the child contact. Angela pro-actively asked for any information to be sent to her about what the group was doing that week so she wouldn't miss out.

9.10.2 The next group session on 12/03/2020, Angela shared a lot of her feelings around isolation.

9.20.3 On the 18/03/2020 the group was cancelled due to the COVID19 pandemic.

9.20.4 After the cancellation of the course Angela had a 1 hr 30min call with SIDAS, on 20/03/2020, to finish the programme contents over the phone. Angela stated the group had been *'invaluable to her'*. Angela then initiated contact with the other women via the SIDAS worker so they could stay in contact and support each other.

9.20.5 No further support was given to Angela from the commissioned specialist domestic abuse service from March 2020 until her death in January of 2022, this is despite Angela experiencing domestic abuse and stalking throughout those two years. Her case did remain open to SIDAS and was transferred to the new commissioned provider on 1st April 2020.

9.21 April 2020

9.21.1 During the spring of 2020 Kevin began the Building Better Relationship programme with the, now discontinued, Community Rehabilitation Company. This is a court mandated programme designed for perpetrators of domestic abuse, to address their behaviour and foster change. As part of this programme partners and ex-partners are allocated a partner link worker to ensure they are supported through the duration of the course. This provides information for the programme facilitators if perpetrators

are not changing their behaviour, and it also focuses on safety because risk of perpetrators behaviour escalating can increase during these courses.

Kevin was referred to the course as part of his sentencing requirements post his convictions.

9.21.2 On 18/06/2020 Angela called her partner link worker (PLW) to explain she wanted to give some feedback as she is not experiencing any relationship improvement. Angela mentioned that she had a family court date to discuss maintenance on 01/07/2020 and wanted to speak to someone before then.

9.21.3 The PLW texted Angela back the same day (18/06/2020) to say she would call her on Monday 22/06/2020. A letter was sent to Angela on the 22/06/2020 but no call was made.

9.21.4 A further six days passed before Angela received a call from the PLW on 29/06/2020 - 11 days after she had initially contacted them. On this call Angela and the PLW talked at length about Kevin's behaviours. Angela explained that Kevin was still being verbally and financially abusive to her and now also to the children, by using financial mechanisms as leverage, in particular with their daughter.

Angela described how Kevin now wanted her and the children evicted from their property and that a bailiff had attended her home due to Kevin's debts, she disclosed that Kevin had been made bankrupt five years ago and without her knowledge he had put a charge on the house. Angela talked about the historical incidents Kevin subjected her to, including a time when Kevin had put a knife in her hand and told her to kill him in front of the children. She also explained again about Kevin hacking into her Facebook and mentioned that he had sent messages to all her contacts. Angela told the PLW that she had really benefitted from the Overcoming Abuse course and was currently having Eye Movement Desensitization and Recovery (EMDR) therapy online and finding it useful.

Angela and the PLW worker agreed to speak again after the court hearing on 01/07/2020.

9.22 July 2020

9.22.1 On 03/07/2020 the PLW called Angela, as arranged, to talk about what happened at court. The call focused largely on the impact on Angela's emotional wellbeing. The PLW offered to refer Angela to more counselling and Angela was very positive about this. Angela described how she had good support from friends and family but didn't really want to talk to them about the situation anymore. The main abusive patterns from Kevin now were psychological.

9.23 August 2020

9.23.1 In August of 2020 the counselling assessment was confirmed and the PLW sent a text to Angela on 27/08/2020 to confirm the first appointment.

9.24 September 2020

9.24.1 Angela text back the PLW on 07/09/2020 stating she was pleased about the counselling starting. Angela disclosed she was having issues with her eldest son, and she also stated that Kevin had now refused to pay anymore child maintenance. Angela disclosed that she had seen Kevin for the first time in a year and he had put his middle finger up at their daughter - Angela commented that there was *'no change in his attitude.'* Angela signed off the text by stating:

"Hope BBR [perpetrator programme] will help but it's pretty dismal so far!"

9.24.2 Kevin had initially been referred to the BBR programme in March 2020, but due to missed appointments and disengagement, he was suspended from the programme and didn't properly re-start until November 2020.

9.25 October 2020

9.25.1 On the 05/10/2020, Angela had an appointment with her GP. She described how she was finding it really tough due to the domestic abuse she was experiencing. Angela explained how it was especially hard with three children with special needs, several court cases, and financial issues. Angela said she would contact talking therapies again and go on the wating list. The GP noted that Angela was coping incredibly well despite the difficult situation.

9.26 November 2020

9.26.1 On the 23/11/2020 Angela called 101 to report that Kevin was continually breaching the RO, she told the police she had called them on the advice given to her by the Family Intervention Service (FIS).

9.26.2 The Restraining Order was not recorded on the police system, the correct order was subsequently placed on the system, therefore officers were incorrectly informed that the order had expired. Once the paperwork was corrected, it was confirmed that the right address was on the order and was in date until 04/06/2021. The police agreed not to pursue this as a 'minor breach' of harassment order, their assessment included that Angela and Kevin's daughter was the only witness to this incident and they did not feel it was proportionate to take a statement from her for a 'minor' breach. In addition, Children's social care stated they would be closing the case because Kevin and the eldest son would not engage in any support services.

9.26.3 NB: No support services were offered to Angela from police following this incident.

9.26.4 Even though the domestic abuse did not cease (see recorded information below) Angela reported no further incidents to the police after November 2020 until her death in January 2022.

9.27 December 2020

9.27.1 On 09/12/2020 Angela left a voicemail for her Partner Link Worker (PLW). She said that counselling was going well but wanted to know if Kevin had started his perpetrator programme yet because:

'Things have gotten worse and become catastrophic for her and the children.'

9.27.2 The PLW called Angela back the same day and they had a further discussion. Angela talked at length about the impact that Kevin was having on her eldest son and how he was replicating some of the abusive behavioural patterns of his Father, at this stage Angela had to cut contact with her son, this really distressed her.

Angela also described how Kevin had not attended a court case in June that he was an applicant for, as a result the judge ordered no contact. In addition to this Kevin had now *'cut off'* the children's phones and she was waiting for a further court hearing so she could get a spousal order to get maintenance from Kevin, he is claiming that he will not pay because he doesn't trust what Angela will spend the money on.

Angela explained that her divorce hearing was in January 2021.

Angela also informed the PLW that Kevin had a new partner and felt this was important in the risk management of his behaviour.

9.27.3 On 10/12/2020 the PLW text Angela to let her know that the information had been passed on regarding Kevin's new partner.

9.27.4 On 18/12/2020 Angela called her PLW. Although the PLW was on leave she answered the phone as she knew Angela had been struggling. Angela was very tearful on this call and talked about how much her eldest son's behaviour was getting to her. Angela also talked about her other two children and the PLW reassured her that FIS had told Angela that she was doing all she could to safeguard her younger two children. They agreed to speak after Christmas.

9.28 January 2021

9.28.1 On the 06/01/2021 Angela and her PLW had a text conversation with each other. The PLW asked if Angela wanted a chat. Angela texted the PLW and talked a bit about how Kevin was now ignoring the younger two children and hadn't sent any presents to them for Christmas, despite this Angela said she had a peaceful Christmas due to no contact from Kevin, she stated:

> *"…he has nothing to take away now and is good for me to see he is a hopeless case so actually we are moving forward."*

Angela went onto say:

> *"I don't think talking about it will help, it has kind of opened everything back up and stupidly some hope of decent behaviour through BBR [perpetrator programme], which sadly isn't happening, and he makes no effort at all with the children."*

The PLW replied saying she respected Angela's wishes not to talk and said she wouldn't call again as she didn't want to cause her any distress, the PLW told her Angela she could call anytime. Angela replied:

> *'Thank you. If there's any info which you think will help us that's fine. I just feel like I'm now involved in a charade where Kevin[9] is still centre of focus. I don't*

[9] Text of the message referring to real name of perpetrator changed for anonymity

think that it is productive or helpful for me or the children after enduring so much already. I initially thought it may help everyone to engage but all it does is highlight how important Kevin's behaviour is to everyone's life and prolongs that feeling of wanting resolution and decency but, we will just learn that he is compliant and going through the motions on a course that is mandatory, and helps him move through parole, again all about Kevin. If you can forget your own children at Christmas and still want to punish, whilst claiming to be happy and peaceful in your new life, I would think that there is no intention of change. I would conclude it is deliberate, and that there is pleasure in those decisions. It's not healthy to enquire at this point as to how Kevin is responding, but to look at his actions and our current reality that really is paramount to staying centred …. any reports on perceived progress or learning more about his life I think will not help. Thank you'.

9.29 February 2021

9.29.1 On 01/02/2021 Angela texted her PLW back explaining that she wanted to give feedback after Kevin had finished his BBR course, she stated:

"Although it is keeping the wound open by communicating about Kevin[10], I would still like to give feedback after the BBR course finishes. I think it's important that there is data you correlate, for the facilitators, and to have the closure for the experience as it was a heavy time investment to provide the info and go over everything, and for victims this is pretty traumatic when you are trying to move on post event. So glad to have the sign off call, thanks."

The PLW texted Angela back reassuring her that she will definitely call once Kevin had finished the course and told her to call if she needed further support. They had a further exchanged where Angela said she had felt very supported by the PLW and thanked her.

9.29.2 On the 23/02/2021 Angela saw her GP for possible long COVID, she explained that she felt very fatigued. At this stage Angela was back on HRT and felt her menopausal symptoms were being managed well. However, she also reports that she is feeling unmotivated, and her sleep is erratic.

9.30 April 2021

9.30.1 In April, on the 28/04/2021, Angela texted her PLW again to ask if Kevin had completed the course as she wanted to give feedback. The PLW called Angela straight away and they had a conversation. Angela talked about how destructive Kevin still was and the impact on the children. Angela stated she felt that Kevin was a "*narcissist"* and that no course would help him change.

The PLW and Angela talked about what would happen when the restraining order came to an end and Angela said he may just turn up and tell his daughter they can see each other now. The judge ordered that Kevin would not be able to see the children until he had completed BBR, and Angela disclosed that Kevin had previously

[10] Text of the message referring to real name of perpetrator changed for anonymity

told the CAFCASS officer that he didn't want to see the children anymore, even though he had made an application to the court for contact.

The PLW and Angela agreed to speak again soon.

9.30.2 On the 30/04/2021, Angela self-referred to talking therapies again, she was requesting an emotional health check and said she was dealing with long COVID.

9.31 May 2021

9.31.1 In May of 2021, on 07/05/2021, a referral was made to the chronic fatigue service (CFS) by the GP. Noted symptoms of fatigue, sleep disturbance, headaches, and muscle aches. It was also noted by the CFS that Angela was a victim of domestic abuse.

9.31.2 On the 10/05/2021 Angela had a conversation with her GP, she stated she felt unable to cope without HRT (self-selected cessation in taking HRT). Angela restarted HRT after reporting mood swings and feeling tearful.

9.31.3 Two weeks after self-referring to Talking Therapies on 12/05/2021 Angela had an assessment with them. The notes state '*it is hard to recognise if this is current issues with long covid or long covid with trauma from Domestic Violence'*. Talking Therapies were unsure if she needed their service.

Angela was given information on how to do an online course (Recovery College Course for mental health) and told to contact Talking Therapies in the future. She was discharged from the service.

9.32 June 2021

9.32.1 On 07/06/2021 the PLW called Angela as Kevin had completed his BBR course. They discussed when the restraining order, the PLW explained that it may be extended as Kevin had some outstanding community work hours to complete.

9.32.2 On the 16/06/2021, Angela spoke to the Chronic fatigue service. She stated she doesn't know if she needs this service and has been *'completing lots of forms from different services'*. She was discharged from CFS service (see section 11.4 Information Sharing for further analysis).

9.33 November 2021

9.33.1 On 12/11/2021 Angela self-referred to talking therapies again. Angela described the domestic abuse as still ongoing via economic abuse, she also disclosed she had experienced physical abuse in the past. Angela stated she feels she has low self-esteem and wants to get back to work but it is difficult with 3 children with special needs. Angela explained that she is still dealing with financial fallout from the civil court cases and remains exhausted from long COVID. Angela disclosed that she had

previously undertaken Eye Movement Desensitization and Recovery (EMDR) therapy via zoom during lockdown but was not able to deal with trauma due to ongoing domestic abuse. Angela told the service that she had found the previous therapy offered by Talking Therapies helpful in 2018.

9.33.2 On the 25/11/2021 – Angela did not attend her appointment.

9.33.3 On the 15/12/2021 Talking Therapies made a call to Angela to re-book. Angela was driving with children and became upset, stating how unhappy she was with multiple services. The Talking Therapy notes state she appeared *'confrontational'* on this call.

9.33.4 On 17/11/2021 Angela was called by her Probation Link Worker (PLW), for a review call five months after Kevin had completed his BBR. Angela explained how much her children were suffering and that she had got her daughter some counselling. Angela thanked the PLW again for being so *'warm and caring'* which is what *'people in her situation need'*. The PLW explained Claire's Law[11] to Angela in case she needed it in the future. The PLW closed Angela's case with consent from Angela herself.

9.34 December 2021

9.34.1 On the 20/12/2021 Angela had a further conversation with talking therapies. Angela was again described as initially *'very confrontational'*, the notes state that Angela calmed down and apologised by the end of the call '*for the way she had acted'*.

On this call Angela explained that she had left her husband 3 years ago and describes flash backs, guilt for not protecting the children, alongside and the shame and anger associated with the domestic abuse she had been subjected to. Angela stated she struggles to cope with her children's needs. She said she would like Interpersonal Therapy (IPT) to help with her depression.

A referral was submitted to IPT.

9.35 January 2022

9.35.1 On the 10/01/2022 Angela spoke to her GP; she was very tearful and struggling with her mental health. Angela said she was on the waiting list for Talking Therapies. She described how she was struggling to sleep but has no thoughts of self-harm because *'the children need her'*.

9.35.2 On the 18/01/2022 the GP called Angela. The case notes list mixed anxiety and depressive disorder. Angela says she is not functioning well, she describes being shaky and having poor sleep. Angela says she does yoga and dog walks, but further explains to GP that she has had lots of problems with stalking and harassment from Kevin, as well as financial problems.

Angela said her first session with Talking therapies was due that day but was cancelled. Angela was Prescribed anti-depressants.

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11 https://assets.publishing.service.gov.uk/media/6489ab97103ca6000c039ea0/Domestic_Violence_Disclosure_Scheme.pdf

9.35.3 This was the last agency contact with Angela just a few days later she died by suicide, may she rest in peace.

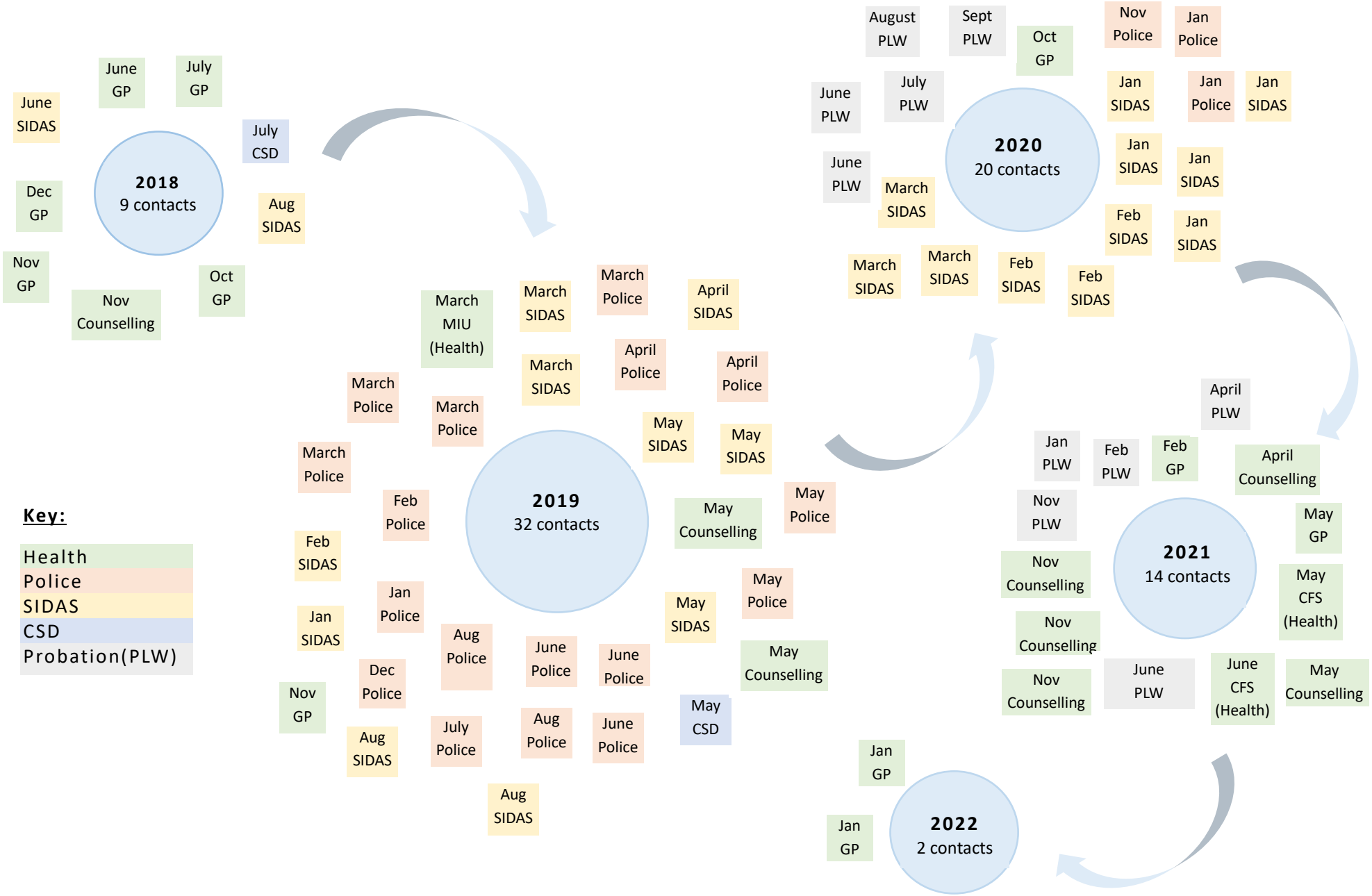
9.35.4 Below is a visual descriptor (p.35) of Angela's contact with agencies over the review period, she spoke to various different agencies on 77 separate occasions from June 2018 to January 2022.

It should be noted that these are only the contacts the review panel knows about, there were many more that were noted by the family, including but not limited to all the family court processes that Angela dealt with as a litigant in person. Due to her children's special needs and the many financial issues Angela was dealing with, we can confidently assume that there will have been more agencies and professionals that Angela was dealing with, that the review panel are unaware of.

9.35.5 Family voice:

A copy of the timeline chronology was sent to Angela's parents. Her Mother contacted the chair and gave her views:

> *"Thank you for your detailed report, which as you predicted I would find distressing! I feel so proud of my daughter for always trying to get help and also felt so sorry for her at the lack of understanding from trained professionals. She was an eloquent woman; I dread to think of other women's experiences when they are not strong enough to ask!"*


2018
9 contacts
June GP
July GP
June SIDAS
July CSD
Dec GP
Aug SIDAS
Nov GP
Oct GP
Nov Counselling
2019
32 contacts
March MIU (Health)
March SIDAS
March Police
April SIDAS
March SIDAS
April Police
April Police
March Police
March Police
May SIDAS
May SIDAS
March Police
May Police
Feb Police
May Counselling
Feb SIDAS
May Police
Jan Police
May SIDAS
Jan SIDAS
Aug Police
June Police
June Police
May Counselling
Dec Police
Nov GP
May CSD
Aug SIDAS
July Police
Aug Police
June Police
Aug SIDAS
2020
20 contacts
August PLW
Sept PLW
Oct GP
Nov Police
Jan Police
June PLW
July PLW
Jan SIDAS
Jan Police
Jan SIDAS
Jan SIDAS
June PLW
Jan SIDAS
March SIDAS
Feb SIDAS
March SIDAS
March SIDAS
Feb SIDAS
Feb SIDAS
2021
14 contacts
April PLW
Jan PLW
Feb PLW
Feb GP
April Counselling
Nov PLW
May GP
Nov Counselling
May CFS (Health)
Nov Counselling
Nov Counselling
June PLW
June CFS (Health)
May Counselling
2022
2 contacts
Jan GP
Jan GP
Key:
Health
Police
SIDAS
CSD
Probation(PLW)

10. Independent Management Reviews

10.1 Independent Management Reviews were submitted to the panel from the following agencies:

- Avon &and Somerset Police
- Somerset NHS Foundation Trust
- Children's Social Care
- Probation Service
- Somerset Independent Domestic Abuse Service (SIDAS)
- Education
- Somerset ICB

10.1.2 Of the above IMRs the following agencies provided IMRs in relation to Angela only.

- SIDAS
- Somerset NHS Foundation Trust
- Somerset ICB

10.1.3 The IMR provided by Education had very limited information which did not contribute or detract from the other IMRs, it was therefore disregarded from analysis. Further information did come to light during the course of the review analysis where Education could have held more information regarding Angela and her children, and the CSP lead reached out to Education to ask for more details. However, the response was not forthcoming. Having experienced sporadic input from Education in previous reviews, the panel felt it important to note that professionals in Education needed to be better supported to contribute to Domestic Homicide Reviews, and this is reflected in the multi-agency recommendations (section 14). The Home Office Quality Assurance (QA) panel (see appendix B) commented that a representative from Education on the panel would have been a useful addition to the review and could have provided more insight into the issues the children were experiencing around the abuse. The panel agreed with this and will add this to the full recommendation for education representatives in Somerset.

10.1.4 The representatives from the panel fed back to the chair of the review that the IMR template was presented in a challenging format. The chair and author of this review has reflected on this feedback and a recommendation is reflected for the Chair in the single agency action plan - see section 14 of this report.

10.1.5 Prior to detailing the IMR information it is important to understand the process for safeguarding in Somerset:

- The First Response team is the front door social work team for Somerset Children's Social Care reviewing all new request for involvement for a statutory social work response based at the police station at Express Park, Bridgwater.

- Somerset's multi-agency safeguarding hub (MASH) works alongside the First Response social work team and equates for approximately 1% of safeguarding work. Somerset Children Social Care are co-located at the police station with health partners, from Somerset Foundation Trust, and the Local Safeguarding Unit (LSU) for Avon and Somerset police.

- The MASH allows for a multi-agency framework through a shared professionals meeting in order that safeguarding referrals and information is reviewed and explored between partner agencies to inform threshold. Typically, these are cases where more information is required to be shared between agencies potential safeguarding concerns may be present or additionally when a multi-agency response is required to agree actions. This does not account for cases whereby threshold to hold a strategy discussion is clearly met.

10.2 Individual Management Review – Avon and Somerset Police

10.2.1 The chronology report evidences 25 domestic incidents for the review period. This included assault, harassment, stalking and verbal incidents – 4 of which reported by Kevin against Angela and 21 reported by Angela against Kevin. 4 of the reports made by Angela were for assault, all of which Kevin was prosecuted and convicted for.

10.2.2 Most incidents occurred during 2019 (n.23 reports during 2019), and there was a peak of activity leading up to the time the family court date in July 2019. There were 2 domestic incidents between Kevin and Angela in 2020 and none reported to the police in 2021 or 2022.

10.2.3 Panel Observations – Good Practice and Learning Points

The IMR from the police noted the good practice of the investigations and convictions against Kevin for violent incidents. The same officer dealt with most of the incidents, and this was noted within the IMR as:

> *"…particularly helpful because he had a good oversight and was able to easily identify when incidents had been reported by Angela[12] more than once"*

Whilst undertaking the review the author of the IMR noted whilst considering practice against policy and guidance, that this had been followed on nearly every occasion. Further the author noted that some officers had gone *'above and beyond'* and demonstrated excellent practice, this will be fed back by Avon & Somerset Police to the individual officers.

10.2.3 Restraining order – The police rightly picked up the issue with the restraining order and the incorrect address placed on the order which meant that it could not be actioned. Although they confirm they would not have taken any action for the reported breaches of restraining order from Kevin, the police have been proactive in ensuring that the communication between the court manager to ensure that administrative errors like this do not occur again.

[12] Name changed for anonymity

10.2.4 Referrals to other agencies - The IMR author clarified that from the police perspective they made onward referrals to all agencies in the appropriate manner and in line with their policies. The panel asked for clarifications regarding the timely and consistent nature of referrals to Children's Social Care (CSC). The police representation at panel provided a detailed rationale for the decisions made.

There were some differences of opinion at panel as to the rationale for the referrals not made to CSC and this will be discussed further in section 10.4 Children's Social Care IMR and the analysis section 11.4.

10.2.5 The IMR author also noted the timely and appropriate use of the DASH form with Angela. The author states that the review of the DASH forms were:

> *"broadly considered to have been appropriately rated according to the score and the wider context and risk at that time, whether victim-led or officer perceived."*

The DHR author had the benefit of the combined chronology and was able to provide the full timeline of the DASH forms that Angela undertook with all agencies. Over a period of 3 years, Angela was required to complete 21 DASH forms, 17 of which were undertaken by the police. There were many discrepancies in the risk level attributed to Kevin's behaviour, in addition Angela was asked to complete a DASH form sometimes within days or hours of a previous incident, as such the use of the DASH and its purpose will be discussed further in the analysis section 11.1 – DASH Risk Assessment.

10.2.6 The panel observed and agreed with the IMR author that there was a key consistency in the same officer dealing with Angela across multiple incidents. This continuity was noted and can be of real benefit to victims of domestic abuse.

10.2.7 The panel agreed that the officer dealing with the majority of reports from Angela had clearly been committed to ensuring robust action was taken against Kevin and that the police pursued criminal sanctions against Kevin. However, the panel questioned the lack of robust pursuance of the coercive and controlling behaviour and stalking offences Kevin submitted Angela to, this will be analysed further in section 11.2 - Coercive and Controlling Behaviour and Stalking and harassment.

10.2.8 It is noteworthy that Avon and Somerset police were proactive in charging Kevin for his behaviour – resulting in five charges, four of these charges were for physical assaults and one was for malicious communications. All four convictions for violent offences were upheld. The charge for malicious communications was dropped by the Crown Prosecution Service (CPS).

10.2.9 The police were exemplary in their pursuance of each reported physical incident and the panel commend the officers in their excellent practice noted by the IMR author. However, the panel felt that there was a distinct lack of 'joining the dots', and that reported incidents were generally treated as separate offences. This was particularly noteworthy with regards to the Stalking and Harassment that Angela was experiencing, and the use of the DASH risk assessment forms the police undertook with her, these points will be discussed further in the analysis sections 11.1 and 11.2.

10.2.10 As stated, the vast majority of reports from Angela were made in 2019, due to one of the convictions, Kevin was given a restraining order. Notwithstanding the issue with regards to the incorrect address on the restraining order, which was the fault of the court, the police did not charge Kevin with any of the breaches of bail or restraining order that Angela reported. Although the police gave rationale for their decision making with regards to these incidents the perception of victims is vitally important in these reviews, therefore this will be further analysed in section 11.2 Coercive Control and Stalking and Harassment.

10.2.11 The police dealt very well with a number of counter allegations made by Kevin. In total Kevin made four allegations against Angela and these were directly after she had reported him for offences against her. The panel noted the good practice the police applied to Kevin's reports - they dealt with these in a proportionate manner and none of his claims resulted in charges against Angela.

10.2.12 Recommendations - There were no recommendations offered from Police on their IMR. Although the IMR author asserted that no further training was needed within the force it was noted that Avon & Somerset police have now commissioned SafeLives to undertake DA Matters training[13] across the force.

10.2.13 The panel agree that DA Matters will be a welcome contribution to the understanding of police officers with regards to coercive and controlling behaviour. However, the panel feel that Avon & Somerset Constabulary require a deeper understanding of stalking and harassment legislation and the impact of stalkers behaviour on victims. DA Matters training is specifically focused on CCB and does not adequately respond to the lack of knowledge in the force with regards to stalking and harassment. Therefore, the panel have addressed this gap in the multi-agency recommendations.

10.2.14 In addition, the panel note the recommendations put forward by CSC with regards to information sharing involving Avon & Somerset Constabulary. This will be further discussed in section 10.4 under the CSC IMR and represented in the Action Plan (S.15).

10.2.15 Finally, the panel welcome the initiative of a new trauma informed working group which is being set up within the force, and the panel will extend this to recommend a multi-agency response with regards to trauma informed practice to foster cultural change for all agencies to expand trauma informed knowledge for professionals.

10.2.16 The above recommendations will be reflected in sections 14 and 15 of this report.

10.3 Somerset NHS Foundation Trust

[13] https://safelives.org.uk/training/police

Angela had interactions with three separate services across Somerset NHS Foundation Trust. These services included:

- Talking Therapies
- Minor Injuries Unit
- Chronic Fatigue service

10.3.1 – Talking Therapies:

The service is described by the IMR author as follows:

> *"Talking Therapies is the Somerset Improving Access to Psychological Therapies Service in Somerset. Offering treatment interventions to people aged 18 experiencing symptoms of anxiety and/or depression and to those who have experienced single incident trauma."*

The IMR author described Angela as having five 'episodes' of care from Talking Therapies. All of these interventions were provided to Angela after she self-referred for counselling support via her GP.

Episode 1 - The longest of these interventions was during the latter stages of 2018 and into early 2019 where Angela had eight sessions of counselling. Angela described the extensive domestic abuse she was experiencing from Kevin. It is noted that Angela refers to how much these sessions helped her to leave her relationship with Kevin when she later self-referred in 2022 (Episode 4).

Episode 2 – In May 2019 Angela re-referred to counselling – she was not offered counselling on this occasion, but the therapist did liaise with Angela's IDVA, and it was the assessment concluded that because of the court cases Angela was dealing with, as well as presenting with trauma linked to past domestic abuse it would be better for her to be referred to a domestic abuse group support programme in a town outside Somerset. There is no evidence within the IMRs that Angela attended this group.

Episode 3 – In April 2021 Angela contacted Talking Therapies again asking for an 'emotional health check'. This coincided with the referral to the Chronic Fatigue Service for possible long COVID that Angela was experiencing (see below). Angela was discharged from the service again as the assessment noted:

> *"Hard to recognise if current issues are due to long covid or long covid with trauma from previous domestic abuse."*

Episode 4 – In November of 2021 Angela went back to Talking Therapies again stating she was dealing with the trauma of ongoing domestic abuse. She also mentioned the impact this was having on her children and their mental health. Unfortunately, Angela was not able to attend the appointment set.

Episode 5 – Angela was contacted by Talking Therapies in December 2021 to re-book her appointment*. After a further assessment appointment was made for Angela in January 2022 for Interpersonal Therapy. Angela tells the GP that this appointment was cancelled - this was just before her death. There is no recorded evidence of a cancelled appointment on the chronology report, but given Angela was so pro-active in seeking support there is nothing to suggest that this did not occur.
**Angela was described as confrontational on this call (reference chronology December 2021) – this will further be discussed in the analysis section 11.6 - Trauma Informed Practice.*

10.3.2 – Minor Injuries Unit

Angela attended the minor injuries Unit twice during the review period. One of these incidents was for a gardening injury. However, the other attendance was after Kevin had assaulted her on 18th March of 2019.

> *"Angela disclosed the domestic abuse she was experiencing with the staff at the MIU, and she understandably presented as 'upset'. Angela was treated for tissue injury to left cheek, upper arm, left forearm, and wrist."*

10.3.3 – Chronic Fatigue Service

The Chronic Fatigue service contacted Angela once after a referral from her GP. Angela was discharged from this service after initial assessment.

10.3.4 Panel Observations – Good Practice and Learning Points

The IMR author rightly points out that there was some good multi agency work done by Talking Therapies, particularly in reference to Episode 2, where the therapist contacted Angela's IDVA and referred her on to a group work programme. There was also evidence of good management oversight in ensuring that Angela got support for the trauma she had experienced due to the abuse from Kevin.

However, the IMR author also surmised that due to Angela experiencing non-recent domestic abuse that she had fallen in between the gaps in support during her latter referrals. Having assessed the full chronology and spoken to the family the panel were of the view that Angela was still experiencing ongoing abusive behaviours from Kevin, and she was also dealing with ongoing trauma related to past abuse. On her final contact with the GP, three days before her death, Angela disclosed that she was having issues with 'Stalking and Harassment'.

The IMR author notes that Angela should have been risk assessed using the DASH on at least two occasions, once with Talking Therapies in 2018 and again when she attended the MIU.

Angela did consistently link her mental health to ongoing domestic abuse and the author makes reference to prolonged domestic abuse resulting in victims having complex needs and multiple disadvantages – this will be discussed further in section 11.6 - Trauma Informed Practice.

The IMR author states that although:

> *"Assessment, escalation, and signposting is evident throughout the chronology. There are incidents where the non-recent abuse was not addressed or explored. There were alerts on Rio electronic records which were visible to MIU, Talking Therapies and the Chronic Fatigue Service that Angela had been a victim of domestic abuse. These alerts should have ideally promoted staff to enquire with Angela if she was currently safe and this did not always happen."*

In addition, it is noted that Angela had children with special needs and a safeguarding referral could have been made on episode five of her interactions with Talking Therapies – this will be discussed further in analysis section 11.8 - Children.

10.3.5 Recommendations

The IMR author noted that policies and procedures have moved on significantly since Angela's tragic death. More training and support have been provided to staff within the Talking Therapies service. In addition, the MIU staff now have a safe space for staff to take patients that have disclosed domestic abuse, they are now able to call the new SIDAS service provider and their duties on undertaking both DASH risk assessments and safeguarding referrals.

The author of the IMR urged the panel to review support for victims where patients were not deemed to be suffering from current domestic abuse, stating this was an apparent lack of provision in Somerset. Two further recommendations were offered by the author. All three recommendations were accepted by the panel and presented in Single Agency Action Plan, section 15 of this report.

The panel will further recommend a multi-agency response with regards to trauma informed practice which will include health professionals to victims (see section 11.6).

10.4 Children's Social Care

10.4.1 Childrens social care received eleven referrals for Angela and her children over the review period. Social care made note of the fact that all three of Angela and Kevin's children had a neurodivergent diagnosis. The IMR author noted that no referrals were received regarding the family prior to the review period.

10.4.2 The first referral social care received was initiated by Angela and was in regard to her two eldest children. Angela was requesting support for neurodivergence and

both children were placed on a waiting list for support. Angela's third child received a formal diagnosis of relating to neurodivergent issues in February of 2020.

10.4.3 The rest of the contacts with Angela were in regard to domestic abuse incidents. Some of these reports were in relation to her eldest son who was displaying violent behaviour against both Angela and the youngest two children. Angela became estranged from her eldest son for a period of time due to this behaviour and when the author of this report spoke to the family, they commented on how much this affected Angela – this will be further discussed in the analysis section 11.8 - Children.

10.4.4 In total social care received five referrals regarding Kevin's abusive behaviour from different agencies over the review period. One report was received via education to the Early Help Support services in June of 2019 resulted in Angela being assigned a Getset worker from Children's Social care. Angela remained open to Early Help Support for the period of eleven months.

10.4.5 The support from the Getset worker was analysed in detail by the IMR author and the interventions noted were around support for Angela in relation to the domestic abuse she was being subjected to from Kevin. The Getset worker noted that Angela engaged well with support and although she sometimes appeared *'chaotic'*, the Getset worker attributed this to the emotional abuse she was experiencing from Kevin. Angela did disclose stalking and harassment and sexual violence from Kevin whilst working with the Getset worker (see sections 11.6 and 11.2 Trauma Informed Practice and CCB/Stalking and harassment for further analysis).

10.4.6 Although there was no formal involvement from children's social care, the Getset worker and IMR author felt this was the appropriate response to the abuse Angela and the children were experiencing. There was evidence of good multi agency referrals by the Getset worker, for both Angela and the children.

10.4.7 Panel Observations – Good Practice and Learning Points

<u>Multi agency referrals to Children's Social Care</u>

The IMR author noted that they had not received referrals for the family on all the incidents reported to the police. On the 1st April 2019 CSC received the first referral from the police in relation to domestic abuse. Following this on 20th May 2019 the second referral from the police was made to social care. By this time there had been 14 reported domestic abuse incidents to the police, dating back to January 2019.

The IMR author noted that this should have fostered a further interrogation between the LSU and CSC, and although this may not have resulted in any formal intervention from social care a Team Around the Child meeting may have been initiated.

Further information was requested by the panel from the police in their rationale for the referrals sent late or not made to social care.

The police IMR author provided the panel with rationale for the late referrals. Although they surmise most referrals were made promptly pointing out that the referral pathway is direct to the Local Safeguarding Unit, there were discrepancies on the timeframe of the definition of 'prompt' referrals. Given some of the referrals from police to CSC were between 3 to 19-days, the representative from CSC challenged the further commentary from the police, stating they would expect to see reports within one working day of the safeguarding incident. The panel support this view but note that the police work around complex frameworks regarding safeguarding that do not always enable application of referrals to social care in one working day. The continuing discussions and work between CSC and the police to improve the system of referrals are a positive outcome of this case.

In addition to the decision the police made in not referring to CSC on two occasions, the police IMR author sent the panel the Niche log entry from the officers who made the decisions. Both entries report they believe that the children are not likely to suffer significant harm and or that the risk is not deemed to hit the threshold for CSC intervention.

10.4.8 It was reassuring to the panel that the representative from CSC reported the robust work now being done between CSC and the LSU, with training and direct mentoring being offered across the wider Avon and Somerset force. This intervention directly addresses the quality and timescales of reports being sent from the police to CSC (see 10.4.13).

10.4.9 Notwithstanding the further discussions regarding timely referrals for social care intervention, the panel note that on at least one of these recorded incidents the children were in the property, in addition the CSC IMR author noted that it is safe to assume that the children were further exposed to high levels of parental conflict. They further assert this would have been *"particularly difficult for the children in light of their additional needs and vulnerabilities"*. The risk of psychological harm to children of witnessing violence and abuse in the home is a well-established safeguarding risk[14].

10.4.10 The panel would assert that psychological harm on children and adult victims of domestic abuse is hard to quantify and the sharing of information between agencies is vital to ensure a full picture is known by all those working with victims and their children. This will further be discussed in the analysis sections 11.4 and 11.8 - Information Sharing and Children. Multi-agency recommendations are offered by the panel in section 14 of this report.

10.4.11 Interventions with Kevin

There was only one conversation with Kevin during the review period. This was with the Getset worker, and they noted that he made several counter-allegations against Angela. The lack of intervention with Kevin was made on assessment of exacerbating

[14] Ref – Children and DV

the risk to Angela, this was after they had received information from the police that he took no responsibility for his behaviour.

From the reported incidents to CSC and the benefit of hindsight, the panel would agree that the appropriate interventions were calibrated by social care to Angela and the children.

10.4.12 Recommendations - The IMR author noted that given the frequency of reported domestic abuse incidents a MASH discussion should have been convened in May 2019. Although the author does conclude that the interventions from CSC would likely not have changed, multi-agency information sharing may have been of benefit in terms of Angela's mental health and ensured identifiable gaps were not missing from agency interventions.

In addition, the IMR author suggests that a lead professional would have been a welcome addition prior to FIS involvement and the Team Around the Child (TAC) meetings. This would have ensured support was coordinated for Angela at an earlier stage. The panel strongly agree with this recommendation, especially given her conversation with her support worker at the SIDAS group in February 2020 where she referred to the TAC meetings stating:

> *'lots of professionals and me, it is getting really impersonal, and I really don't want to go!'* (Angela to SIDAS worker, February 2020)

We know that Angela's request was not responded to by SIDAS (see section 10.6 SIDAS IMR and 11.5 Domestic Abuse Advocacy Services) had they been more involved at an earlier stage of Angela's journey this could have fostered better outcomes for the family.

10.4.13 A further recommendation was made by the IMR author with regards to follow up correspondence with the GP.

10.4.14 The single agency actions were accepted by the panel and further multi-agency actions were recommended in section 14 of this report.

10.5 Probation Service

The Probation Service provided the panel with two IMR reports. The reports relate to two separate interventions as a result of Kevin's convictions:

- Offender Management – sentence management report for all offences
- Building Better Relationships (BBR)

10.5.1 Offender Management IMR - Kevin was managed by a Community Rehabilitation Company at the time of his offences. CRCs have now been disbanded

and all offenders are now managed under the Probation Service in a public sector organisation.

10.5.2 Kevin was initially sentence in July of 2019 to a 12-month Community Order for the offence of assault by beating.

10.5.3 In December of 2019 Kevin was further sentenced to an 18-month Community Order with the Building Better Relationships (BBR) programme, and 80 hours of unpaid work.

A Restraining Order was ordered on conviction of the above with the following terms:

1. Not to enter Angela's road
2. Not to contact Angela directly or indirectly except via a third party or by email, text, or letter, and then only in relation to matters concerning the children or financial affairs.

This order lasted until 04/06/2020.

10.5.4 Kevin completed his BBR programme in May 2021. Due to the global pandemic, there are some outstanding unpaid work hours, and these have been extended for him to complete.

10.5.6 Panel Observations – Good Practice and Learning Points

Risk assessment - The IMR author notes that although the offender manager (OM) completed a police intelligence check in July 2019, there was no evidence that this was completed at the time of Kevin's sentence. The author is of the IMR asserted that this would have been essential to inform the Pre-Sentence report author and the court of the full risk of Kevin's offending behaviour towards Angela and her children. The full details of Kevin's offending and the pattern of his behaviour would have contradicted Kevin's claims that he was the victim of domestic abuse from Angela. The IMR author noted that Kevin would also claim this repeatedly in the BBR programme, and there was no record of him being challenged on these claims, which evidenced his denial of the impact of his behaviour on Angela and the children (see section 11.2 Coercive and Controlling Behaviour/Stalking and Harassment).

10.5.7 Kevin did not attend any of the court hearings in relation to his children. We have evidence of Angela mentioning this to her PLW on December 19th, 2020 (see 9.27.2) where she described:

> *'Kevin had not attended a court case in June that he was an applicant for, as a result the judge ordered no contact. In addition to this Kevin had now 'cut off' the children's phones and she was waiting for a further court hearing so she could get a spousal order to get maintenance from Kevin, he is claiming that he will not pay because he doesn't trust what Angela will spend the money on.'*

10.5.8 The IMR author flagged concern that there was a lack of professional curiosity on CSC previous engagement with the family, there was also no evidence of contact between the OM and the GetSet worker. Although Kevin was assessed as low risk of harm to his children, and contact was regularly made to CSC, there was a gap in information sharing. There was evidence of his seeking access to them through the family courts and good practice should facilitate information sharing between probation and social care professionals.

10.5.9 The IMR author correctly identified an issue with challenging Kevin's narrative on not attending the court hearings. It is contradictory to seek contact through the family court and then not attend, and this evidences a use of the family court system to further facilitate his abuse of Angela – a fact backed up consistently in national research findings from other victims[15] (see analysis section 11.8 Children).

10.5.10 The chronology additionally evidences a lack of information sharing on Angela reporting Kevin for breaching his restraining order (see section 11.4 Information Sharing for further analysis).

10.5.11 Management of behaviours

Kevin undertook a self-assessment questionnaire where he identified the triggers for his offending behaviour, these included:

- Accommodation
- Loneliness
- Temper/Acting in the spur of the moment.
- Financial issues
- Stress
- Poor thinking skills

Although self-identified issues, financial stress and poor thinking skills were not added to his sentencing plan.

10.5.12 BBR was completed and signed off in line with policy, as there was no further police intelligence or reported incidents. The benefit of hindsight offers us the perspective that Angela was still experiencing abuse from Kevin, and she also fed back to her PLW that her experience of his behaviour change from BBR was non-existent.

10.5.13 COVID19 had a significant impact on delivery for the management of offenders, and BBR was completed by phone. The pandemic had an impact on other agencies service provision (see section 11.7 COVID19 and the impact on domestic abuse victims).

[15] https://www.womensaid.org.uk/family-courts-remain-an-unsafe-and-traumatic-place-for-women-and-children/

10.5.14 There was some good practice noted by the IMR author and the panel, namely that the BBR programme facilitator changed their working schedule to accommodate Kevin's work pattern. In addition, there was regular contact between CSC and the OM, although the information was lacking on their contact and liaison, this practice is imperative to keep children safe and interrogate offender's behaviour. Finally, although intermittent, when it did occur there was good communication between the OM and the PLW which will be discussed further below.

10.5.15 Recommendations - The IMR author has made four single agency recommendations all of which are agreed by the panel and represented in Section 15 of this report.

10.5.16 **Building Better Relationships (BBR) IMR**

Kevin was subject to an order to complete BBR, which is a perpetrator programme designed to challenge domestic abuse and foster change and reflection for offenders. When an offender is instructed to complete BBR a Domestic Abuse Safety Officer (DASO) is assigned to the victim. Under CRCs this role was referred to as a Partner Link Worker. The job of the PLW was to contact Angela throughout Kevin's programme and share information about the programme, signpost to other agencies, assess risk and develop safety plans.

10.5.17 Panel Observations – Good Practice and Learning Points

10.5.18 There were some discrepancies on whether the PLW should have contacted Angela sooner, and some procedural issues with time lapses were noted, but generally any issues were not deemed to be consequential by the IMR author. The panel would agree with this.

10.5.19 One of the roles of the PLW is to undertake a safety plan with the victim and there was no record of these discussions. The PLW did state that no formal plan was required as Kevin was adhering to his RO. Angela also expressed that she was more concerned around the impact on the children at this stage, including Kevin's lack of interest in them, and his financial and emotional abuse which they were all being subjected to from him.

10.5.20 The IMR author identifies the need for robust information sharing between the PLW and the BBR programme facilitator. Kevin's offending behaviour was not adequately recorded, which would have made it difficult for other professionals to run the programme with Kevin should they have needed to (see section 11.4 Information Sharing for further analysis).

10.5.21 Perhaps more concerning was the lack of information on effective delivery to address risk within the BBR programme. The IMR author noted that when some examples were fostered in real life scenario situations, the learning with Kevin was

'told' to him by the facilitator, rather than Kevin being encouraged to explore through his own learning.

Crucially there was no evidence when the effect on children of domestic abuse was explored in the programme if Kevin was encouraged to think about how his behaviour would have affected his own children. The panel observed that Angela had fed back to the PLW that her issue was with how Kevin was treating the children, she also fed back that she had seen no significant change in his behaviour when the course was completed.

10.5.22 Good Practice – the panel and the IMR author observed the supportive relationship between the PLW and Angela. It is clear from the notes that although Angela saw no change in Kevin's behaviour through BBR, she felt very supported by her PLW. Although the IMR author noted that the PLW could have referred Angela to specialist services the panel noted that with the benefit of the full chronology we know that Angela had been offered support from SIDAS and her experience was at points lacking from this provision – this will be discussed further in the analysis section 11.5 Domestic Abuse Advocacy Services. The PLW did make an appropriate referral to counselling services which Angela said had been very helpful. It was also noted by the panel that Angela felt able to be open and provide feedback about the programme to her PLW.

The panel would further note the PLW's good practice in trauma informed care, this will be referred to in the analysis section 11.6.

10.5.23 The panel further noted the positive work being developed in Somerset by the Probation Service after learning an analysis was applied due to a number of cases where a more consistent approach was identified as essential:

- Probation Service in Somerset have set up a Somerset wide approach to MARAC, called MARAC POD. The Probation Service have invested additional Probation Officer resources and case administrative time. The aim is to develop a Single Point of Contact approach, enhance expertise, provide knowledge and experience of working with perpetrators for other agencies.

10.5.24 Recommendations – The IMR author made four single agency recommendations, and these were agreed by the panel and are represented in s.15.

10.6 Somerset Independent Domestic Abuse Service Livewest (SIDAS)

At the time Angela was seeking support, Livewest were the organisation commissioned to deliver SIDAS services. The contract ran from January 2015 to the

end of March 2020. The service was re-commissioned from 1st April 2020, and The You Trust was awarded the contract.

Specialist domestic abuse services are independent of all other organisations and are commissioned by local authorities to provide support, advocacy, refuge and guidance for victims and their children.

Angela was in contact with and or sought support from Livewest within the following time frames:

- Period 1: 25th June 2018 – Angela called SIDAS but no follow up from SIDAS
- Period 2: 3rd August to 3rd September 2018 (1 month – 1 positive contact)
- Period 3: 11st January 2019 to 11th February 2019 (1 month – 1 positive contact)
- Period 4: 23rd February 2019 to 13th June 2019 (4 months – 8 positive contacts)
- Period 5: 24th July 2019 to 29th August 2019 (1 month – 2 positive contacts)
- Period 6: 6th January 2020 to 24th March 2020 (3 months – 9 sessions of Overcoming Abuse group programme, 1 phone call to complete sessions due to COVID19 pandemic)

The positive contacts recorded relate to times when Angela was spoken to directly by the SIDAS service. Although there were other attempts to call Angela (as listed below) we can see that between period 1 and period 5, from June 2018 to August 2019 when Angela was seeking one to one support, she was only spoken to directly thirteen times.

The most prolonged period of direct support was given to Angela during the group work sessions she attended in early 2020.

10.6.1 Panel Observations – Good Practice and Learning Points

The IMR author highlighted various points of learning throughout the review process. There was some discrepancy on the original IMR submitted and when the contact ended with Angela. The current service provider was able to give more details to the panel on Periods 5 and 6.

10.6.2 Period 1: We know that Angela pro-actively contacted the SIDAS service for support in June of 2018. Angela mentioned to her GP on 29th June that she had undertaken a questionnaire with the SIDAS service, and we can assume that this was a DASH risk assessment form, she was assessed as medium risk on this contact. Angela was internally allocated for support, but this was not allocated, and she did not receive a call back.

10.6.3 Period 2: Angela called SIDAS again 26 days after her initial call. She stated she had been waiting for a call but had not received one. From the chronology report we can see that 4 calls and 1 text was sent to Angela during this period, but no engagement was obtained. Angela's case was closed one month later.

10.6.4 The panel notes that although Angela sought support from the SIDAS service in 2018 she did not receive any. This was a missed opportunity when Angela had taken the brave decision to reach out for help on two separate occasions.

10.6.5 Period 3: Angela was referred to SIDAS services by the police after a physical incident perpetrated against her by Kevin. Although 4 attempts at contact were made to Angela there was no answer.

10.6.6 Whilst she was due to be on annual leave, the allocated worker attempted to ask her colleagues to try calling Angela. This request was denied. The IMR author notes that this was a *"poor decision"* by the Manager not to not cover call attempts during annual leave, as this would have built on Angela's motivation to engage.

10.6.7 The case was closed by SIDAS after 4 attempts at contact and the reason for closure was stated to be 'non-engagement' by Angela, this will be analysed further in section 11.6 Trauma Informed Practice. The allocated worker did go back to the referring agency and inform them of the decision to close the case, this is noted as good practice by the IMR author and the panel agreed with this comment.

10.6.8 The panel note that this is the third time Angela has been referred or has self-referred to SIDAS services, but she still hadn't received any meaningful support.

10.6.9 Period 4: The LSU contacted SIDAS again to state that Angela had called in to them to state she had no missed calls or contact from SIDAS. The decision was made to re-open the case and Angela was contacted.

10.6.10 SIDAS were able to contact Angela on the number provided and this was noted as strange by the SIDAS worker with the question of a possible bug being put on the phone by Kevin. However, the IMR author made no comments in regard to the possible stalking behaviour Angela was being subjected (see section 11.2 Coercive and Controlling Behaviour and Stalking and Harassment for further analysis).

10.6.11 At this stage Angela was assessed by SIDAS to be high risk of domestic abuse under the DASH risk identification checklist and was referred to an IDVA. The IDVA had eight meaningful contacts with Angela before her case was closed just under three months later. The author of the review noted that although there is a reference to safety planning discussions with Angela and the IDVA, there is no formal recording on the SIDAS chronology of an Individual Safety plan. Recorded safety plans with input from the victim would be a standard requirement and this should be repeated and or referred to at every contact, or when the risk behaviours of the perpetrator changes.

10.6.12 The IMR author noted that discussions around a non-molestation order focused too heavily on Angela to progress these actions herself, and they would have expected more support around the issues that Angela faced. The author of this review agrees with this assertion and the panel make a further recommendation regarding the use of appropriate services for victims seeking non-molestation orders. In addition,

there was a lack of information sharing between the IDVA and CSC. The IMR author noted that a referral to CSC should have been made and the progression of support via the SIDAS service for the children was not followed up.

10.6.13 The panel noted from the chronology report that after 3 contacts discussions were already happening internally about closing Angela's file. The rationale for this appears to be that there had been no further physical incidents, given this conversation occurred within less than a month of the initial referral the panel noted this was concerning practice. The absence of physical injury does not equate to an absence of risk (see sections 11.5 and 11.1 Domestic Abuse Advocacy Services and DASH Risk Assessment for further analysis).

10.6.14 Another concerning feature of Angela's interactions with services at this time was that her case was not listed at MARAC, the rationale for this was that she was working with the IDVA and seeking a non-molestation order. Just three calls later and under two months after this rejection from MARAC, (based on the rationale that Angela was getting support) the IDVA closed her case (see sections 11.1 DASH Risk Assessment and 11.4 Information Sharing).

10.6.15 – Period 5: Just over a month after her case being closed, Angela was referred back to the IDVA service by the police. The panel will assert that Angela's case should not have been closed by the IDVA and this will be further analysed in section 11.5 Domestic Abuse Advocacy Services.

10.6.16 Although not commented on by the IMR author, the panel noted that on allocation to IDVA on this occasion, the manager stated:

> *"Can you call her and do some safety planning; I don't think this will be open for long."*

At this stage Angela had been in contact with the police, social care, her GP, and SIDAS. She would have undertaken numerous safety plans. The panel assert that this direction was misguided and further raise the concern that the manager was setting the scene for short intervention when they had no real idea of what Angela may have needed. The short and intermittent support Angela was offered by SIDAS looks to be like common practice at this stage and this may have been an organisational culture to get victims in and out of services as quickly as possible. This will be further analysed in section 11.5 Domestic Abuse Advocacy Services.

10.6.17 The repetition of Angela's case not being heard at MARAC occurred again during this period. The same rationale was given, namely, that Angela had support from the IDVA service. On this occasion the IDVA closed Angela's IDVA case just three days later. Although not picked up by the IMR author, this was a concerning trend in SIDAS's decision making for Angela's case.

10.6.18 On closure Angela was referred to the Overcoming Abuse course run by SIDAS. It would be a further five months before this course started.

10.6.19 Period 6: Angela was contacted by SIDAS in January of 2020 to inform her of the Overcoming Abuse course starting. She was understandably frustrated at only being given 3 days' notice. Angela had been waiting for eleven months for a referral to group as she had originally requested it at the beginning of 2019. The SIDAS worker did note her feedback and liaised with her to ensure that her concerns were raised.

10.6.20 Angela attended all the sessions bar one when she had to attend court. She was described as being a positive member of the group. Angela clearly got a lot out of the course and made friends with the other women. The Overcoming Abuse course run by the SIDAS service appears to be the most beneficial intervention Angela had from independent domestic abuse services.

10.6.21 There were further reported incidents to the police during this period of time. Angela continued to attend group and another IDVA referral was made by the police for Angela due to one of these incidents. Although not commented on by the IMR author the panel noted that the IDVA rejected the referral with the rationale that she was:

> *'fully aware of support services having accessed them before'*

A further comment was made by the Overcoming Abuse facilitator that Angela had not mentioned the incident at group, and the response was that she would:

'pop it in her file'.

Although the IMR author did not comment on this decision making the panel would assert this as concerning practice. Not least because again the onus is placed on Angela to initiate support, but perhaps more concerning, the rationale and following process does not address the safeguarding risks of a victim being deemed at risk of serious harm or murder. This makes the process of risk assessment and the commissioning of independent advocacy meaningless (see section 11.1 DASH Risk Assessment for further analysis).

10.6.22 It was noted by panel that no recorded referrals to CSC were made by Livewest, which would have been common practice under safeguarding duties, and particularly relevant to children with intersecting needs of autism.

The IMR author incorrectly notes that SIDAS were involved in the Team Around the Child and commented this as best practice. As previously stated, Angela had asked for support at a meeting describing her experience of these meetings as follows:

> *'lots of professionals and me, it is getting really impersonal, and I really don't want to go!'*

However, the panel observed that there was no record that Angela was offered any support or advocacy around the TAC meeting. The CSC IMR (see 10.4) rightly notes that Angela should have been afforded a lead professional prior to the involvement of FIS and the TAC meeting and it would be common practice for the independent domestic abuse advocacy service to provide this support, particularly after Angela requested it herself. The panel will recommend this as an action see S.14.

10.6.23 Recommendations: The IMR author did not submit any recommendations to panel, as the service had now been recommissioned and they were no longer the provider.

10.6.24 The panel have made a series of single agency, multi-agency and national recommendations to develop and enhance learning in the Violence Against Women and Girls (VAWG) sector. In addition, these recommendations and this report will be sent to Livewest to review their policies and procedures to develop their practice.

10.7 Somerset CCG IMR

The Somerset ICB represented detailed information with regards to Angela's contact with her GP surgery.

Over the requested review period of four years, there were 29 contacts with Angela, 8 of which were directly related to the domestic abuse she was experiencing.

Angela's last contact with agencies before her death was with her GP surgery where she explained she was *'having a hard time'* and feeling *'anxious'*.

10.7.1 Panel Observations – Good Practice and Learning Points

The panel were incredibly impressed with the level of detail provided by the GP for analysis. This enabled a thorough assessment of Angela's dealings with the surgery.

10.7.2 The IMR author highlighted the excellent practice of the GP on Angela's first disclosure about the abuse she was experiencing from Kevin, in 2018. The GP undertook a through safety plan with Angela, completed a DASH risk assessment form and referred Angela's children to CSC. The GP also gave Angela information, guidance and advice leaflets and referred her to counselling services.

Following on from the CSC referral Angela called the GP back as she was distressed about the impact of having social care involvement. The GP offered reassurance and was able to reduce Angela's distress by explaining the role of social care and how they may be able to help, particularly in relation to her children's autism care needs.

Angela later disclosed to her GP that she had separated from Kevin and this conversation was noted by the IMR author as an open and supportive conversation. The GP referred Angela to Talking Therapies and domestic abuse services for further support.

10.7.3 The above interventions were noted as excellent practice by the panel. Many victims fear social care involvement and need reassurance of the referrals made to them. Honest and transparent conversations about information sharing and safeguarding foster trust from victims and it is clear that Angela trusted her GP and engaged with him well after these discussions. It is also noted that at no point did the GP promise anything to Angela that could not be delivered. He remained faithful to his duty of care of both her and the children's safeguarding, whilst simultaneously enabling a trusting and transparent relationship with Angela.

When Angela did disclose the abuse, she was being subjected to and the subsequent separation she was met with a non-judgmental and supportive response by her GP. This provides patients with an avenue to support for further specialist interventions, and is noted as best practice by the panel, further supported in guidance from NICE[16].

10.7.4 Over the review period Angela began to experience menopausal symptoms. These were managed well by her GP, who understood Angela's preference for non-medical interventions at times. Whilst the panel make no criticism of the GPs interactions with Angela with regards to her menopausal symptoms, new research has proven crucial to the intersecting issues of patients experiencing domestic abuse and menopausal symptoms (see section 11.3 Menopause and Domestic Abuse for further analysis).

10.7.5 Angela discussed low mood and anxiety symptoms with her GP on various occasions. Some of these disclosures were directly in relation to her menopausal symptoms, which is a common side effect, the GP offered support and referrals to counselling services.

However, Angela also described struggling with anxiety and panic attacks in relation to the physical and psychological abuse she had been subjected to from Kevin. Angela also disclosed that her eldest son was displaying abusive behaviour towards her, and she was finding this difficult to cope with. The GP did go through the options available to Angela, but there was an opportunity to do a carers assessment given that her son had a diagnosed neurodivergent issue. Although Angela was aware of the support services on offer in relation to domestic abuse services, the IMR author also correctly raises the added difficulties for victims to disclose child to parent violence and abuse (see section 11.8 Children for further analysis).

10.7.6 Angela's last contact with any external agency was with her GP. She spoke to her GP about feeling "*shaky"* and having poor sleep. Angela explained that her eldest son was now back in the family home and things were going well. However, Angela's daughter was experiencing mental health issues and had attempted suicide some weeks previously. Her daughter was also self-harming.

The GP responded in the consistent way in which he always had. The GP asked Angela if she had any suicidal thoughts or intentions and she explained that her children needed her. The GP went through the options around anti-depressants and prescribed these to Angela. Angela disclosed that she had been due to start her

[16] https://www.nice.org.uk/guidance/qs116

therapy that day, but the meeting was cancelled. It was apparent from the IMR author's report that this meeting was joined up and provided good care to Angela.

10.7.7 The IMR author astutely raises the issues relating to Angela, combined would prove incredibly stressful for her:

> *Many of the GP consultations were around menopausal symptoms and Angela benefited from hormone replacement therapy. During many of the GP consultations there was open conversations about how Angela was struggling with her low mood and anxiety which may well have been a combination of a difficult marriage and breakdown, early menopause and symptoms and coping with caring for three children two of which had neurodivergent issues and one daughter with mental health issues.*

The combined chronology enabled the panel to evidence that one of Angela's first experiences of support came from her GP and her last supportive conversation also occurred with her GP. Clearly Angela trusted her GP and the surgery staff, she reached out to them on several occasions. It is also clear to the panel that the surgery staff and the GP were affected by Angela's tragic death.

10.7.8 Recommendations - The IMR author recommended one single agency action which the panel supports and is reflected in section 15 of this report.

The review author offered a further two recommendations. The first will commend the GP in their excellent care of Angela and the second will be to use the example of the GPs practice to provide other health professionals with a benchmark on how to foster open and supportive discussions with patients experiencing domestic abuse.

10.7.9 Further multi-agency recommendations are offered in section 14 of this report which will further enhance the learning for health professionals.

11. Analysis

The benefit of hindsight enables the Chair and the panel to assess where different decisions or actions could have been a catalyst for support and or intervention for Angela. This analysis is based on information provided in the IMRs, the chronology and, perhaps more importantly, Angela's family supported more focus for the panel to understand a more holistic perspective of the situation.

11.1 DASH Risk Assessment

The use of the DASH Risk assessment tool is well established across the UK[17]. The tool is designed to allocate a risk category to victims, based on the context of the

[17] https://www.dashriskchecklist.co.uk/

behaviour of the perpetrator[18]. The tool has become particularly useful in fostering multi-agency working and a common language in understanding what risks a victim is experiencing. However, the DASH is frequently used incorrectly and professionals all too often treat each reported incident as a separate set of facts. Thereby making victims repeat the same assessment multiple times. This is not what the DASH was designed for, and it is imperative that professionals understand its use is to assess the risk posed by the perpetrator, rather than use it to allocate and map out resources to victims.

Angela undertook 21 DASHs over the review period.

These consisted of:

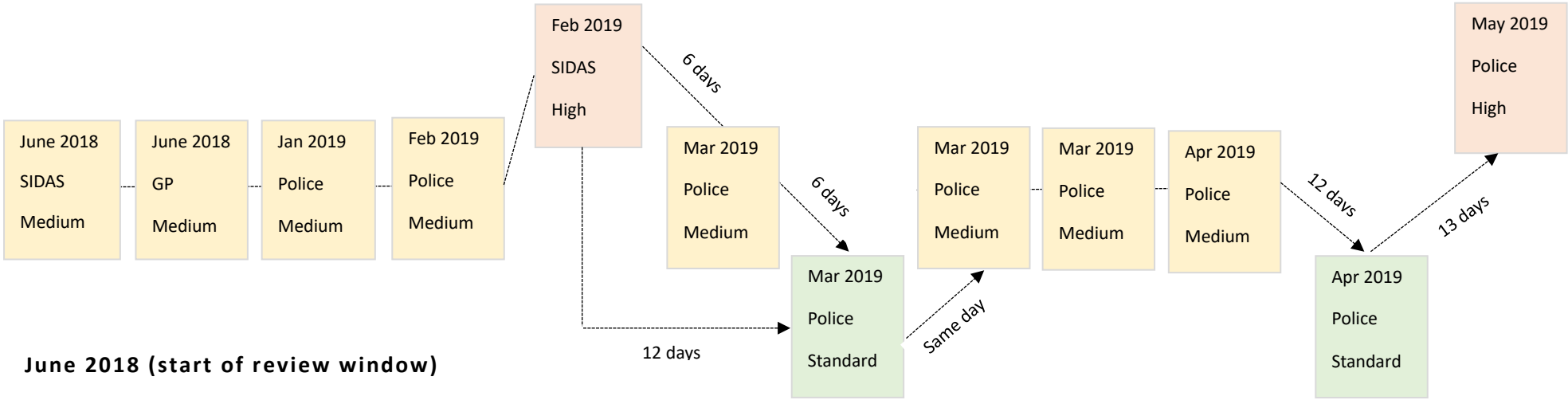
- 17 with Avon and Somerset Police
- 3 with SIDAS
- 1 with GP

All these risk assessments were done with Angela over an 18-month period, between June 2018 to January 2020.

The DASH follows the behaviour of the perpetrator, rather than any incident being reported. The risk of a perpetrator does not change in a matter of days or hours, and the following DASH Timeline graphic that there were discrepancies on the application of the DASH risk assessment from professionals.

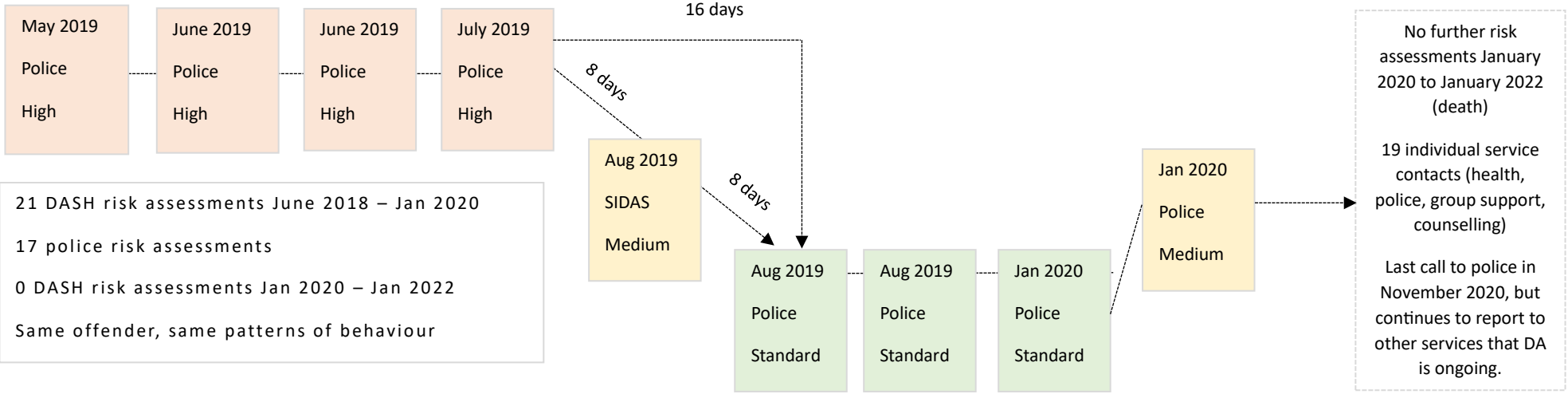
[18] https://www.dashriskchecklist.co.uk/wp-content/uploads/2022/02/DASH-Practice-Guidance-2016.pdf

ANGELA – DASH TIMELINE



June 2018 (start of review window)

January 2022



21 DASH risk assessments June 2018 – Jan 2020

17 police risk assessments

0 DASH risk assessments Jan 2020 – Jan 2022

Same offender, same patterns of behaviour

The risk category assigned to the DASH is as follows[19]:

- Standard - Current evidence does not indicate the likelihood of causing serious harm.
- Medium - There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug, or alcohol misuse.
- High -There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.

From the above timeline we can see that during 2018 Angela was asked to complete two DASHs, one with SIDAS and one with her GP. Both these assessments were graded as medium risk.

In early 2019 Angela was again assessed as medium in January and February respectively, by the police and then when she was subsequently referred to SIDAS by the police her risk was assessed as high risk. This is not unusual; specialist domestic abuse services often enable victims and survivors to disclose additional information about what they are experiencing.

Within 6 days however Angela's DASH had been reduced to medium risk by the police and within another 6 days the risk had reduced to standard, again by the police. On the same day Angela was asked to do another DASH with the police and they scored her as medium.

Further along in the timeline we can see that the police reduced Angela's risk from medium to standard within a 12-day period and 13 days later she was assessed as high-risk. Similarly, later along in the timeline SIDAS received a referral from the police that scored Angela as high-risk, this assessment would have afforded Angela an automatic referral to an IDVA service, it is curious therefore that SIDAS decided to undertake a further DASH with Angela (only 8 days later) and reduce her assessment to medium. A DASH form should not routinely be downgraded unless further intelligence comes to light, this should point to the fact that a victim is likely minimising the abuse in response to the trauma they are experiencing. Only 16 days after the initial high-risk assessment from the police, the police assessed Angela as standard.

This particular issue highlights a misunderstanding of the purpose of the DASH. Incidents and risk are treated as standalone disclosures and the one common thread, that being the perpetrator's pattern of abuse, is lost in a system of process.

The Domestic Homicide review of Clare O'Conner[20] evidenced a similar issue. Varied risk assessment 'scoring' in relation to Angela alternated between standard, medium and high depending on the incident concerned. This promoted the review to raise questions as to how the serial nature of offending is understood as a key risk in its own right.

[19] https://academic.oup.com/bjc/article/59/5/1013/5518314 (p.1017)
[20] https://www.nuneatonandbedworth.gov.uk/downloads/file/2149/overview_report

The review author into Clare's death noted:

> *…how are known perpetrators identified and how are the risks that they pose to others assessed? For example, an initial incident may not be serious, but if it is perpetrated by someone known to present high risks to partners, how can this be factored in and influence the overall risk assessment and risk management plan? (McAteer, 2015, p.76)*[21]

Jackson (2016)[22], researched the importance of understanding risk management and serial domestic abuse offenders, she notes:

> *Both McAteer (2015, p. 70) and Warren (2015, p. 41; 44) emphasise the importance of understanding risk in its wider context, and the need for agencies to raise the risk level where a 'standard' incident is committed by a high-risk offender, a principle referred to by Warren (2015) to as the 'transfer of risk'. The simple concept behind the 'transfer of risk' principle is that the risk in any one case is assessed in terms of the perpetrator, rather than the individual victim or specific incident concerned.*
>
> *…the nationally-recognised DASH (Domestic Abuse, Stalking and Harassment and Honour-Based Violence) risk assessment model (Richards, 2009a) had been completed with the victims on at least one occasion and – in some cases – multiple times. The DASH model provides not only a framework for assessing the risk of harm to the victim, but also - by default - an insight into the perpetrator's patterns of behaviour, which should, in accordance with Richards' (2008, pp. 155-156) specific guidance on the use of the model, then be used to form the basis of a management plan for high-risk offenders. The crucial problem…therefore, was not necessarily the document on which information was collected, but, instead, the way that information was both understood and used in relation to the perpetrator concerned. Put quite simply, utilising the risk assessment process to focus solely on interventions with the victim will always produce a gap in response.*

This is particularly important in agencies communication with victims and survivors. Expecting a victim to complete a DASH on multiple occasions, sometimes within hours of each other, in Angela's case, may leave a victim confused and traumatised at answering the same questions repeatedly. Particularly when the outcome of the assessed risk deemed to be so different, when the offender remains the consistent risk and negative influence in her life.

An assessment of being high-risk of domestic abuse should precipitate a MARAC meeting. However, in Angela's case we can see that her case was never heard at a MARAC. The MARAC doesn't just afford the victim a space where their case can be discussed in a multi-agency setting, but it means the risk is shared, analysed, and

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[21] https://www.nuneatonandbedworth.gov.uk/downloads/file/2149/overview_report

[22] Jackson, Z., 2016. *Developing a Consistent Response: The identification and management of serial domestic abuse offenders in England and Wales.* Masters. Portsmouth: University of Portsmouth

dissected by multiple professionals. The reasons given for not listing Angela's case she that was receiving support from the IDVA service, these issues will be further explored below in Information Sharing 11.4 and Domestic Abuse Advocacy Services 11.5.

The issues with the DASH as a risk assessment tool are not uncommon amongst police forces across the UK. The College of Policing has been working with academics, frontline practitioners, and survivors to pilot the use of the Domestic Abuse Risk Assessment (DARA) model, a new risk assessment tool for frontline police officers. Research undertaken by Professor Amanda Robinson[23] evidenced inconsistencies in the way in which first responders used the DASH and subsequently recorded the risk, these issues were compounded by a lack of understanding on Coercive Control.

Regarding the DASH Robison's (2021), findings evidenced:

> *Both Thornton (2017) and Chalkley and Strang (2017) looked retrospectively at cases of domestic homicide or serious assault assessed using DASH and found a high proportion of 'false positives' and 'false negatives'. It is not clear, however, whether these studies considered the dynamic nature of risk assessment (in other words, a risk grading of 'standard' or 'medium' may have been appropriate at the time of the assessment, even for cases that escalated subsequently to serious harm). In addition, a high false positive rate might be explained in part by effective intervention rather than poor prediction or incorrect risk grading (Chalkley and Strang, 2017). More recent studies (Turner, Medina and Brown, 2019; Grogger, Ivandic and Kirchmaier, 2020) have used machine learning methods to test how accurate data from the DASH is in predicting (further) reports of physical assaults. While both studies concluded that DASH does not predict violent recidivism accurately, they are limited again somewhat by the dynamic nature of risk assessment, and the association of 'high risk' solely with physical assault with injury. In addition, and in contrast, to some risk tools, the DASH was not designed specifically to predict discrete future acts of violence. (Robinson, 2021)*[24]

On piloting the DARA model in three separate police forces the findings were as follows:

> *Wire and Myhill (2018) evaluated a pilot of the DARA in three UK police forces and found first response officers' initial assessments of risk were less likely to be regraded, during a post-incident review, than assessments made using the DASH. They also found that victims in one force disclosed perpetrators' coercive and controlling, and stalking and harassment behaviours, at greater*

[23] https://assets.college.police.uk/s3fs-public/2021-11/Recognising-responding-vulnerability-related-risks-Evidence-review-part-2.pdf

[24] https://assets.college.police.uk/s3fs-public/2021-11/Recognising-responding-vulnerability-related-risks-Evidence-review-part-2.pdf (p.17)

rates using the piloted risk assessment tool, and first response officers recorded proportionately more crimes of coercive control during the pilot (though overall numbers were small). (Robinson, 2021)[25]

The panel welcome the fact that Avon and Somerset Police are undertaking DA Matters training with SafeLives[26]. The panel will further recommend support for Avon and Somerset Constabulary feedback to the multi-agency network regarding the guidance surrounding the use of the DARA model for police forces nationally.

Further multi-agency recommendations for other professionals to understand the importance of the context of risk behaviours and information sharing with perpetrators of domestic abuse will be reflected in section 11.4 of this report.

In addition, the panel will offer a national recommendation that victims are informed and supported to tell other agencies what the grading of a current risk assessment is. Victims can then work with other agencies if they are asked to complete the assessment again following any further incidents. Victims deserve to have agency over the processes that professionals apply to them, given that Angela was so pro-active in seeking support it may have been beneficial to her and to the professionals who undertook the risk assessments with her if she was able to tell them that she had already completed a DASH days or hours earlier and what the risk was. Although risk is dynamic and does change, victim voice is essential in understanding context and in enabling a sense of trust and understanding in the reasons for a risk allocation. The ability of victims to inform professionals of the risk posed to them through previous assessments fosters a sense of empowerment for the victim and free flowing information sharing to professionals.

After reading the final version of the review Angela's family agreed with the above analysis and wanted to stress that they felt the way she presented could have been a disadvantage for her with professionals:

"She was quite upfront, direct and eloquent about her needs, [and] we don't feel she was taken seriously or put at high risk as she was able to express her need, or that annoyed services who didn't like to be told what 'To do'. It's as if being an intelligent women got her punished."

11.2 Coercive and Controlling Behaviour and Stalking and Harassment:

Coercive control legislation came into effect in the UK on the 29th of December 2015 and was therefore in force as a crime when Angela was experiencing domestic abuse from Kevin. Thus, it is important to analyse this as a factor in the relationship between Angela and Kevin. To understand domestic abuse holistically we must understand that

[25] https://assets.college.police.uk/s3fs-public/2021-11/Recognising-responding-vulnerability-related-risks-Evidence-review-part-2.pdf (p.18)
[26] https://safelives.org.uk/training/police

coercive and controlling behaviour acts as the backdrop to physical and or sexual violence[27].

The cross-Government definition of domestic violence and abuse outlines controlling, or coercive behaviour as follows:

- Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

- Coercive behaviour is a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

- Controlling or coercive behaviour does not only happen in the home; the victim can be monitored by phone or social media from a distance and can be made to fear violence on at least two occasions or adapt their everyday behaviour as a result of serious alarm or distress.[28]

We can see from the beginning of the review period that Angela was describing being subjected to Coercive and Controlling Behaviour (CCB) from Kevin. In her first contact with her GP, she discloses the economic abuse Kevin is wielding over her. We also know from interactions with Angela's family that Kevin was controlling from the start of the relationship. As described in the summary section 1.9 of this report:

> *Angela became pregnant within one month of her and Kevin meeting and from the outset Angela's family noted that Kevin was controlling. When talking to the chair of the panel, the family relayed an incident a friend of Angela's had recalled. Kevin had come into the living room whilst they were chatting one day, he had barely spoken to Angela's friend and Angela had explained this was just how he was. Angela and her friend popped out of the house and when they came back Kevin had cut the wire to the Television to stop them from watching it.*

Controlling behaviour was a consistent feature of the abuse Angela experienced and she tried, like many victims to manage this abuse. In early 2019 Angela disclosed the typical signs of controlling behaviour from Kevin in her contact with SIDAS. Angela described again the financial control Kevin had over the family and explained how Kevin would change online banking information and fraudulently claimed different income streams to make things difficult for her. She also described this to her PLW in

[27] https://www.theduluthmodel.org/wp-content/uploads/2017/03/PowerandControl.pdf

[28] Controlling or Coercive behaviour in an intimate or family relationship – Statutory Guidance Framework – Home Office December 2015 p. 3-4 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf

June of 2020, explaining how Kevin was using financial mechanisms as leverage particularly in relation to her daughter.

Angela's family corroborated her experience. In a conversation with the chair of the panel, the family described how Angela was constantly struggling with money due to Kevin's financial abuse. Kevin would give the children access to bank cards and if they ever used it on food shopping, he would cut them off. Right up until her death she was dealing with multiple issues in relation to the finances for the family, including a charge on her mortgage that Kevin had placed on the property without her knowledge, and unpaid child maintenance fees that Kevin was refusing to pay.

Experts note that economic abuse rarely happens in isolation and often occurs alongside other forms of abuse[29]. Research evidences[30] that economic abuse has devastating and enduring consequences for victims, and further research directly with victims evidences the long-term mental health implications of financial abuse[31].

Aside from the financial abuse Angela was being subjected to, she disclosed CCB in her conversations with all agencies. She described in detail Kevin's tactics including the manipulation of her parenting skills, shaming of her menopause symptoms, using the BBR programme to 'go through the motions' in order to remain compliant and sending her unwanted gifts. Angela also self-referred to counselling for the ongoing physical, psychological, and financial abuse she was being subjected to from Kevin.

Many of the disclosures and incidents Angela reported about Kevin had the feature of stalking and harassment behaviours. Post separation abuse for victims who have experienced coercive control will often manifest in stalking behaviours from ex-partners[32] and this was a consistent feature for Angela.

Angela reported incidents to Avon and Somerset police on 21 separate occasions. Only four of these were for physical violence, the rest were listed as either verbal domestic abuse and or Stalking and Harassment. In these reports Angela described being *'tracked'* by Kevin and that he knows what she is doing *"all the time".*

On one occasion Angela reported the online cyberstalking that Kevin was subjecting her too via Facebook. The police listed this incident as a *'domestic incident with no offences'* advice to Angela was to close her account; they noted on their system that Angela *'refused to do this'*. This type of advice to victims of stalking is incorrect and not beneficial. Alongside the fact that closing social media accounts can restrict and isolate victims further, research has repeatedly evidenced that stalkers will find other access points to continue their pursuant behaviour[33] and in addition it can be very beneficial for victims of stalking to keep their accounts open and track, mute,

[29] https://survivingeconomicabuse.org/
[30] https://archive.ilr.cornell.edu/sites/default/files/Economic-Abuse-Untold-Cost-of-DV.pdf
[31] https://survivingeconomicabuse.org/wp-content/uploads/2020/11/SEA-Roundtable-Report-2018-1.pdf
[32] https://www.researchgate.net/publication/227019371_Why_Doesn't_He_Just_Leave_Me_Alone_Persistent_Pursuit_A_Critical_Review_of_Theories_and_Evidence
[33] https://pubmed.ncbi.nlm.nih.gov/21351134/

screenshot as well as block stalkers[34] – these actions ensure robust evidence when investigating stalking crimes.

Psychologist and leading expert in stalking, Lorraine Sheridan[35], explains that stalking is really about the motivation for the behaviour rather than the behaviour itself. In many cases, it involves the targeted repetition of otherwise ordinary or routine acts. What those behaviours look like can be expansive and ever creative; they include following a victim, monitoring via the internet, or other electronic communications, use of spyware, CCTV, tracking devices, interfering with property, and loitering outside public and private spaces.

Angela's family recalled a conversation with her in the months leading up to her death, where she came out of the house and was looking around for Kevin's car. She explained to her Mum that she had to do that every day and was constantly looking over her shoulder. We also know that Kevin followed Angela in her car, and she reported this incident. The police concluded that there was no damage to the vehicle and therefore 'no offences' had occurred. The review author asserts that the damage to the car is irrelevant, it is the psychological alarm and distress that needs to be recorded and investigated, in line with legislation[36], when victims of stalking report the crimes against them.

The Suzy Lamplugh Trust reports[37] that an estimated 1.5 million victims were subjected to stalking in England and Wales in the year 2019-2020, yet only 2% of these cases were reported to the police, in the year 2020-2021 these reports increased by 300%, taking the reported cases from 32,217 to 98,863 – this difference is likely due to the changes in reporting structures for UK police forces, but we also know that during the global pandemic stalking soared in England and Wales, because victims were sitting targets being confined to their homes[38].

One of the first occasions of Angela reporting Stalking to the police resulted in them giving Kevin 'words of advice'. This practice could be attributed to a Police Information Notice (PINS) which is a practice now deemed to be inappropriate in cases of stalking and harassment[39]. The Avon & Somerset police decision was one month prior to the

[34] https://sigbi.org/st-albans-and-district/files/Cyberstalking-Presentation.pdf

[35] Weller, M., Hope, L. and Sheridan, L. (2014) *Police and Public Perceptions of Stalking*.

[36] https://www.cps.gov.uk/legal-guidance/stalking-and-harassment

[37] (2022) *Bridging The Gap - A Stalking Advocate for Every Victim*. Suzy Lamplugh Trust.

[38] Bracewell, K., Hargreaves, P. and Stanley, N. (2020) "The Consequences of the COVID-19 Lockdown on Stalking Victimisation," *Journal of Family Violence* [Preprint]. Available at: https://doi.org/10.1007/s10896-020-00201-0.

[39] https://researchbriefings.files.parliament.uk/documents/SN06411/SN06411.pdf

College of policing guidance[40] stating the police forces should stop issuing PINS with immediate effect.

It is imperative that police and other professionals join the dots on stalking behaviours. When treated as isolated incidents the pattern or persistent, fixated, and obsessed behaviours are not adequately tracked and thus offenders are not brought to justice.

As discussed, Angela reported breaches of the bail conditions regarding her Facebook account, after request the police confirmed the bail conditions were for Kevin not to contact Angela either directly or indirectly, other than to arrange access to children, and not to attend her address. Although the police made the decision that these were not breaches, from hindsight we can see a course of persistent stalking and harassment conduct from Kevin to Angela in both online and offline behaviour.

Angela was successful in securing a Restraining Order against Kevin and she subsequently reported several breaches of the RO to the police. None of these were pursued by the police. On her final report to the police Angela reported a breach of the order the police marked this as a 'minor breach'. Any breach to a victim is important, no matter how minor and taken within the context of all her reports the author of this report would assert that there was enough evidence to investigate stalking and harassment from Kevin towards Angela. The panel make national recommendations (see 14.2) regarding restraining orders, as these issues are not unique to Avon and Somerset Constabulary, they are an issue for the full gambit of the criminal justice system. Centre for Women's Justice Super Complaint[41] findings were largely upheld by Her Majesty's Inspectorate of Constabulary, Fire and Rescue Services. Avon and Somerset Police agreed with this summary and have separately commissioned work on Protection Orders and response to breaches of restraining orders, under the Force Vulnerability Working Group.

In addition, the SIDAS service noted that Angela's phone could be bugged, and that Kevin had fixed two of the children's iPads. These are risk alerts to take notice of when a victim is disclosing stalking, but there is no evidence to suggest that the service shared this intelligence with the police or offered her specialist advice on stalking safety measures.

The Home Office Quality Assurance (QA) panel (see appendix B) noted the review did not initially highlight the gaps in knowledge around tech-facilitated abuse, therefore, the review author has further developed this point. As stated, it is clear from Angela's experience that she was being subjected to both online and offline stalking and harassment behaviour from Keven. However, a lack of knowledge from professionals about how Kevin's online and offline behaviour combined to form a pattern of persistent targeted stalking, does highlight the need for professionals in Somerset to understand tech-facilitated abuse in more detail.

[40] https://www.met.police.uk/foi-ai/metropolitan-police/disclosure-2020/january/police-approach-stalking-harassment-cases/

[41] https://www.centreforwomensjustice.org.uk/news/2021/8/23/police-super-complaint-report-shines-a-light-on-police-failure-to-protect-domestic-abuse-victims-as-prosecutions-collapse-by-50-in-just-three-years

Research[42] corroborates the QA panel's observation with regards to the lack of knowledge from professionals in tech-facilitated abuse (TFA), evidencing that little is known about TFA and the relationship with other behaviours that abusers perpetrate, in turn this means that the impact on victim/survivors is relatively unknown. The research[43] also highlighted the unknown of TFA, when victims cannot necessarily 'see' what is happening to them, but they know the stalking is occurring online this amplifies their levels of fear. The findings of the research concluded that all practitioners needed to understand the pervasiveness of TFA, so that they can be alert to its presence and advise accordingly.

In a separate study[44] the use of TFA was highlighted in victims who had already left their partners. Victims reported being subjected to GPS trackers and persistent harassment via text messages and social media. One of the major themes highlighted in this research was the use of technology by perpetrators to punish and humiliate their victims. As described below Angela's sister disclosed the level of distress that she expressed to her having been subjected to abuse from Kevin for a long time, and the TFA element of this abuse cannot be underestimated.

We cannot know how Angela felt about the fact that none of the breaches she reported were actioned, but it is not outside the realms of analysis to conclude that any victim would feel distressed at not only experiencing continued unwanted behaviour from an ex-partner but also feeling that nothing was being done about it. It would be easy to conclude from Angela's perspective that Kevin was simply able to get away with his behaviour. We also know that victims of stalking experience long-term mental health issues because of their experiences, with eight out of ten victims showing symptoms of Post-Traumatic Stress Disorder (PTSD)[45]. In a conversation with Angela's sister, she told the chair that Angela expressed her desired to have specific counselling around PTSD and that she knew she needed support to get over the trauma of the abuse she had experienced.

The panel will recommend multi-agency actions in relation to professionals understanding of stalking behaviour for future victims, including the use of specific risk assessment tools, and a broader understanding of TFA, that support understanding of risk and safety planning for victims of stalking.

11.3 Menopause and domestic abuse

It is noted in the chronology and IMR report from the CCG that Angela was experiencing menopause symptoms throughout the review period. She reported the impact this was having on her wellbeing. There is nothing in the evidence presented in the IMRs to suggest that the GP dealt with her issues inadequately. Although one family member did note:

[42] https://journals.sagepub.com/doi/full/10.1177/23333936211028176
[43] https://journals.sagepub.com/doi/epub/10.1177/23333936211028176
[44] https://journals.sagepub.com/doi/epub/10.1177/1077801216646277
[45] https://www.suzylamplugh.org/fighting-for-my-sanity-stalking-and-post-traumatic-stress-disorder

"Her HRT was not correct and there was very little support getting that right for her which I feel made her depression much worse."

New research[46] has evidenced the links between domestic abuse and the menopause and in particular the importance for health professionals to be alert to the intersecting needs of menopausal women who are also being subjected to violence and abuse.

Symptoms of menopause can affect a survivor's confidence and leave them vulnerable to be exploited, shamed, and humiliated by abusers[47], and we know that in a contact with SIDAS Kevin had used Angela's menopause to shame her in front of her children. Angela's sister also confirmed that Kevin accused Angela of being *"mad"* and taking drugs when she was prescribed HRT.

Domestic abuse can also impact menopausal symptoms *"with negative symptoms or experiences compounding or obscuring one another"[48].*

We also know that women aged between 45-54 years old account for the highest suicide rate amongst females in the UK[49], and although as noted by the Samaritans; '*Suicide is extremely complex and most of the time there is no single event or factor that leads someone to take their own life[50],* research evidences the need to understand the links between depressive and anxiety related disorders and peri/menopausal symptoms[51].

In relation to Angela, she was dealing with very stressful situations and her menopausal symptoms would have undoubtedly added to her ability to manage her wellbeing. The panel will offer multi-agency recommendations in relation to fostering more understanding of the links between domestic abuse and the menopause.

11.4 Information Sharing

From the DASH timeline and throughout the IMR reports we can see that information between agencies was sometimes lacking with regards to Angela. Had the DASH outcomes been shared more frequently between agencies, she may not have been asked to complete it so many times and the risk level would undoubtedly have remained more consistent. This could have facilitated a more comprehensive overview of her risk and needs, and also reduced the trauma for Angela in having to repeatedly answer the same questions about the abuse she was experiencing.

The issue highlighted between the police and CSC in relation to referrals for Angela's children has been addressed in action both agencies are currently taking forward. However, it is worth noting that from the descriptive chronology report Angela was dealing with multiple agencies throughout the review period. At no point is there

[46] https://irisi.org/stuck-in-the-middle-with-you-guidance-for-general-practice-clinicians-to-better-identify-the-link-between-domestic-abuse-and-menopause/
[47] https://irisi.org/wp-content/uploads/2022/02/Menopause-and-Domestic-Abuse-Brief-Guidance-for-Staff-and-Clinicians-in-General-Practice.pdf
[48] https://irisi.org/stuck-in-the-middle-with-you-guidance-for-general-practice-clinicians-to-better-identify-the-link-between-domestic-abuse-and-menopause/
[49] https://www.itv.com/news/2021-11-16/suicide-rates-in-women-of-menopausal-age-rise
[50] https://media.samaritans.org/documents/Media_Guidelines_FINAL.pdf
[51] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6299176/

evidence to suggest that Angela was asked how many agencies she was speaking to. But we do know that she explained to the Chronic Fatigue service that she was *'completing lots of forms from different services',* and in one of her final contacts before her death she became distressed on the phone with Talking Therapies and described being *'unhappy with multiple services'*.

It is often the case that victims are expected to navigate and deal with multiple agencies when they are being subjected to violence and abuse and the sharing of information is noted[52] as vital in terms of safeguarding and promoting the welfare of adults and children being subjected to domestic abuse. As previously discussed, Angela's case was not heard at MARAC, despite the police referring to MARAC on three separate occasions, and this could have provided a vital opportunity to share information on what was going on for Angela.

A lead professional should always be considered best practice for victims, this way they can map out who the victim is working with and aim to reduce the onus put on them to manage communications between agencies.

The author of this report asserts that the best professional to assign as a lead in domestic abuse cases would usually be the Domestic Abuse Advocacy Service and this will be discussed below.

The panel offer multi-agency recommendations in the importance of Information Sharing and rationale for rejection at MARAC meetings when dealing with victims of domestic abuse.

11.5 Domestic Abuse Advocacy Services

It appears that the most beneficial and long-term intervention for Angela from SIDAS was the Overcoming Abuse course. Group facilitation for domestic abuse victims can be an incredibly positive way to foster trust, reduce isolation, and address the issues they are facing.

However other SIDAS interventions were lacking for Angela. We know that she initiated contact with SIDAS in 2018 and her call was not returned due to a process issue. Following another call from Angela, SIDAS were unable to get hold of her. She was therefore not offered any support during 2018 from specialist domestic abuse services.

During 2019 Angela was offered support from the IDVA service at SIDAS, but her contacts were fairly limited and on more than one occasion her case was closed after a very short period of time. On one occasion after only three contacts with Angela her IDVA was already assessing whether to close her file. In addition to this we know that Angela's case was closed to the IDVA and then within one month she was re-referred to the same service. From the records the panel received, the interventions provided by Livewest appear to have been somewhat basic. For example, there was no robust risk management, safety planning or co-produced multi-agency support plan which

[52] https://safelives.org.uk/sites/default/files/resources/A%20Practitioner%27s%20Guide%20to%20GDPR%20-%20England%20%26%20Wales%20version.pdf

addressed Angela's needs and wishes. In addition, there was no advocacy with other agencies or to obtain civil orders. The Home Office Quality Assurance panel (see appendix B), passed comment on their concern for the swift closure of Angela's case by SIDAS, particularly as the risk towards her appeared to be escalating.

The IMR report shows that on one referral the manager at the SIDAS service referred Angela internally with the note: *"Can you call her and do some safety planning, I don't think this will be open for long."* As already suggested the author of this report asserts that this could appear to be a culture of practice within the previous SIDAS provider to get victims in and out of services as quickly as possible. Given the lack of resources afforded to commissioned services this is not a surprise, however, it is imperative that providers feedback to commissioners when they are struggling with caseloads rather than shorten their interventions to fit with unrealistic budgets.

There was no evidence to suggest that SIDAS queried the rejection of the MARAC referrals. They accepted that the rationale for rejection was that Angela was working with them, they then subsequently closed her file on both occasions very shortly afterwards. Worryingly on the second occasion they closed her case just three days after the reason for MARAC rejection was their IDVA service were offering support and therefore managing the risk. The job of the IDVA is to work in a multi-agency framework[53], without multi-agency oversight the management of the risk to victims is limited.

Most concerning was the rejection of the referral to the IDVA service in January 2020, when Angela was referred after a police report for harassment. The reason for the decision not to contact Angela was noted as Angela was *'fully aware of support services having accessed them before'*. The author of this report strongly challenges this decision. Angela was deemed to need an intervention by the police after being assessed as high-risk of domestic abuse. The rationale for not making contact cannot be that a victim already knows the number of the service and can contact herself. The onus and responsibility should not be placed on victims to contact agencies. Once a service knows the risk to a victim, they cannot simply unknow it or do nothing with that information. Specialist domestic abuse services are commissioned to make pro-active contact with victims, to ensure not only their needs are met but that the reduction of harm or serious violence is safeguarded against[54].

Although we know that the IDVA service informed the Overcoming Abuse facilitator of the referral, the response from the facilitator was that Angela had not mentioned the incident in group. This provides clear evidence that Angela was not disclosing everything that was happening to her, which is a common occurrence for victims of abuse. The fact that the service had become aware of further abuse Angela was experiencing, should have facilitated a discussion with her and offer of further support

53 https://safelives.org.uk/sites/default/files/resources/National%20definition%20of%20IDVA%20work%20FINAL.pdf

54 https://safelives.org.uk/sites/default/files/resources/National%20definition%20of%20IDVA%20work%20FINAL.pdf

and or safety planning, the only response we can evidence from SIDAS is from the Overcoming Abuse facilitator stating she would, *'pop it on her file.'*

The panel refer back to the recommendation made in the CSC IMR, where the IMR author asserts that a lead professional should have been supporting Angela prior to her involvement with FIS and then throughout her case. We know from hindsight that Angela asked SIDAS to support her with the FIS meetings. In addition, we are aware from the extensive chronology report and from conversations with her family, that on top of being subjected to domestic abuse by Kevin, Angela was dealing with many agencies, attending criminal courts hearings, acting as a litigant in person for her civil case, being expected to pursue a non-molestation order herself, dealing with the menopause and caring for three children with autism.

From Angela's perspective the enduring stress she was under would have undoubtedly added to her negative mental health. What Angela should have been afforded from the specialist domestic abuse agency is a sharing of the burden, an advocate that represented her and was aware of all the people she was speaking to and all the issues she was facing. These actions by domestic abuse professionals will always alleviate the burden on victims and reduce the psychological stress they are under. From the chronology and the SIDAS IMR we have no evidence to suggest that Angela was ever asked what she needed in relation to communications with other agencies and we can see that she was not only being subjected to long term abuse and stalking from Kevin but as a result of that abuse the onus was placed on her to manage correspondence with a variety of different agencies - in isolation.

The panel note that both the previous and the new commissioned SIDAS provider have the national Safelives Leading Lights accreditation[55], this offers a confidence to the quality of provision within Somerset for victims of domestic abuse. However, it is noteworthy that an accreditation of this kind can ensure processes are best practice, but this does not necessarily equate to a confidence on the content of the work undertaken with victims within the service. The panel will make a national recommendation for SafeLives in section 14.2.

The panel will further recommend that a copy of this report is sent to the previous provider, and that Angela's case is used as a case study in multi-agency training on the importance of pro-active agency contact with victims and lead professionals.

[55] https://safelives.org.uk/practice-support/resources-domestic-abuse-and-idva-service-managers/leading-lights

11.6 Trauma Informed Practice

Trauma Informed Practice across multi-disciplines is being rolled out for professionals. There is a wealth of information regarding the need for services to respond in a trauma informed way to their service users.

The six guiding principles[56] to trauma informed care are as follows:

1. Safety
2. Trustworthiness & transparency
3. Peer support
4. Collaboration & mutuality
5. Empowerment & choice
6. Cultural, historical & gender issues

With regards to domestic abuse victim's trauma informed practice is of paramount importance to foster trust, engagement, and disclosures. There were a number of interactions listed in the chronology reports and the IMRs that lacked evidence of a trauma informed approach from agencies towards Angela.

As a starting point, organisations working in a trauma informed way will approach a person with the question from *"What's wrong with you?"* to *"What's happened to you?"*[57]

Language is an incredibly important aspect of trauma informed approaches, including on internal agencies record keeping. A clear example of this approach with Angela was reflected in the SIDAS notes in 2018. The service did attempt contact with Angela after her second pro-active contact with them, however, they were not able to get hold of her. The reason her case was closed was listed as 'non-engagement'. This insinuates a proportion of blame onto Angela for not taking up support offered to her; however, we know the context from the chronology report that this was not the case. Angela did engage, she contacted SIDAS twice and on the first occasion her case was mismanaged in allocations by SIDAS, on the second occasion the SIDAS worker couldn't get through to her.

Irrespective of the above, a trauma informed approach will recognise that people with trauma in their past or present, may not be ready or able to take up the support offered at any given time. A simple way to apply trauma informed language would be to list a closed case as *'unable to contact'* rather than *'non-engagement'*. The former approach apportions no blame to the victim and ensures that judgements are not made about their motivation to seek support with services if they do come back into the organisation.

Angela was also advised by SIDAS to *'keep boundaries regarding face-to-face contact and wishes regarding the relationship'*. We know from hindsight that Angela was doing everything she could to keep boundaries and she had expressed her wishes regarding the relationship. A trauma informed approach would not put the onus onto victims to

[56] https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm
[57] https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/

maintain boundaries that are not within their control, no matter what Angela tried regarding face-to-face contact, Kevin repeatedly breached these boundaries and as stated above Angela reported these breaches, but no action was taken. The onus is on professionals to rethink their advice to victims, to understand the full picture and to reframe their approach in trauma informed way.

Angela also disclosed sexual violence to SIDAS and to her PLW, these disclosures would have taken considerable bravery and left her feeling very vulnerable. Although there is nothing to suggest Angela was not afforded the utmost care and empathy, after these disclosures trauma informed practice would enable professionals to explore these discussions further and initiate further support in the long-term.

In addition, Angela spoke to Talking Therapies in late 2021, only a few months before her death. The notes from these conversations evidence that Angela was very distressed, and she described being *'unhappy with multiple services'.* The record from the therapist describes Angela as *'confrontational'* and a subsequent conversation describes Angela as *'very confrontational'*, further the worker stated that Angela *'apologised for the way she had acted'*.

We know from the chronology that by this stage Angela had been subjected to long-term domestic abuse from Kevin, she was dealing with multiple agencies and had tried everything she could to survive and move forward. It is unsurprising that Angela was frustrated, Kevin had not stopped abusing her and this was undoubtedly incredibly stressful. Any person in Angela's position could be legitimately angry about what was going on for her, she had nothing to apologise for.

A trauma informed approach would have fostered an interrogative yet empathetic discussion about Angela's feelings of anger and used her display of emotion as a catalyst for understanding her life and what she was dealing with. If recorded well in notes, this type of interrogation means that any further practitioner could refer to the notes of a victim's testimony and understand what is going on for them, rather than being offered information that will inform their pre-judgement of a person as 'confrontational'.

Good practice was noted within the IMR report for the Probation Service. Angela's PLW noted her trauma responses in having to disclose her feelings around Kevin and feedback to the BBR programme. The PLW afforded Angela a trauma informed response and process to Angela, leaving it open for her to come back into the service and offer feedback if she wanted to. From the notes we can see that Angela was listened to by the PLW and the IMR evidences that the PLW did not see her trauma as an act of non-engagement. Rather the PLW gave an open-ended opportunity and the acknowledgement to Angela of her feelings and this space resulted in Angela coming back to the service to offer feedback.

We also know that Angela received counselling support from Talking Therapies, online counselling services and a referral from her PLW. However, on occasions referrals for counselling were rejected because of the other issues that were going on for her. The panel makes no comment on whether or not these were the correct assessments but

do note that from Angela's perspective sometimes when seeking mental health support her efforts were thwarted.

Recent research undertaken by Women's Aid England, notes:

> *The perpetration of domestic abuse is a key driver of women's mental ill health. 45.6% of women in refuge services in 2020-21 reported feeling depressed or having suicidal thoughts as a direct result of the domestic abuse they had experienced (Women's Aid, 2022).*[58]

The research further asserts:

> *The term "trauma-informed" is often used but sometimes without a specific definition. Elliot et al. (2005) defines trauma-informed services as "those in which service delivery is influenced by an understanding of the impact of interpersonal violence and victimization on an individual's life and development."*

In the research victims reported requiring timely and long-term support:

> *Survivors want their mental health support needs to be prioritised, without having to face long waiting times. They also want it recognised that recovery is often not short-term, so support options shouldn't be either.*

One survivor noted:

> *"The most important thing is to be heard and for those professionals to really understand the dynamics and impact domestic abuse has on survivors not just whilst in the relationship but for a lifetime."*

The panel note that this research supports a model of care that is both trauma informed, and specific to the needs of victims and survivors of domestic abuse. The findings support a seven-pillar approach for mental health professionals, commissioners, and local authorities in order to provide affective mental health support for survivors of domestic abuse.

This is particularly important for professionals to understand in terms of domestic abuse victims and the link to suicide. As research states[59]:

> *cross-sectional, prospective and retrospective studies have consistently demonstrated that living with a violent intimate partner is a significant contributor to women's adverse mental health outcomes. The most prevalent sequelae include depression, anxiety and Post-Traumatic Stress Disorder (PTSD). Furthermore, intimate partner violence is strongly associated with suicidality, sleep and eating disorders, low self-esteem, personality disorders, social dysfunction and an increased likelihood of substance misuse…*

We also know that an increased awareness is being highlighted on victims who die by suicide, the recent coroner's report after the tragic death of Lauren Murray[60] in Greater

[58] https://www.womensaid.org.uk/wp-content/uploads/2022/10/DTBH-Final-2.pdf
[59] https://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-10-98
[60] https://bhattmurphy.co.uk/files/SRN%20cases/05.01.23%20SRN.pdf

Manchester, should focus professional's minds to the potential for victims to die by suicide and or use self-harm as a coping mechanism in dealing with the trauma of domestic abuse.

The Home Office Quality Assurance panel (see appendix B) commented on the lack of a trauma informed approach to Angela. The combination of the DASH forms not being joined up in their approach, and the swift discharge from the SIDAS service despite the escalating risk to Angela were all noted. The panel agree and further assert that trauma informed approaches can ensure more disclosure rather than less, training for professionals around trauma informed interventions will assist victims in the future and enhance a joined up and professionally curious workforce.

The panel will offer multi-agency recommendations for trauma informed practice and the seven-pillar approach proposed by Women's Aid. In addition, the panel will recommend further training on suicide awareness, and consideration of the suicide timeline work being undertaken by Professor Jane Monkton-Smith[61].

11.7 COVID19 and the impact on domestic abuse victims

The global pandemic and lockdown measures in the UK were in operation during the review period. The services Angela was dealing with during this period all responded in the best way they could.

The SIDAS group worker finished the course with her over the phone and Angela commented on how much she appreciated this. In addition, the PLW kept good contact with Angela during this period and she engaged well with this service.

The global pandemic meant that services were responding to the needs of victims and perpetrators in unprecedented times and the IMR author for the CCG did note that the impact of the pandemic may have isolated Angela further from family and friends.

We can learn from the emerging findings of research[62] of the impact the pandemic had on victims and survivors of domestic abuse. Although the panel note that services did their best during this time for Angela, we also know that she was entering a period of lockdown isolation having experienced years of stress due to the abuse Kevin was subjecting her to. Her financial pressures from Kevin's abuse are likely to have been exacerbated by the pandemic and many victims reported:

> *Covid-19 exacerbated the economic pressures on victim-survivors. Difficult choices are common themes in the literature, with victim-survivors being forced to choose, for example, between their phones and heating.*[63]

[61] https://eprints.glos.ac.uk/10579/
[62] https://www.womensaid.org.uk/wp-content/uploads/2021/11/Shadow_Pandemic_Report_FINAL.pdf
[63] https://www.womensaid.org.uk/wp-content/uploads/2021/11/Shadow_Pandemic_Report_FINAL.pdf (p.1)

We also know from national research[64] undertaken that there were exacerbating pressures on professionals working with victims and perpetrators. A great deal has been learnt by frontline professionals working in the domestic abuse sector and a more blended approach to working both online and in person has been adopted across the board. This should ensure that any further pandemics do not prevent programme delivery for perpetrators is halted, and that victims can access support in many accessible formats.

11.8 Children

There were some police reports initiated by Angela with regards to her eldest son's behaviour, these were disregarded by the author of this report from the chronology as it was agreed that the importance of reflecting the impact of domestic abuse on children rather than labelling any child a perpetrator of domestic abuse. Angela's eldest son did display behaviour that warranted police intervention and she also mentioned his behaviour to social care, SIDAS, her PLW and her GP. But it is important to note that her son's behaviour was in no way on parity with that of Kevin.

More obviously her son was displaying trauma related behaviours due to the long-term domestic abuse Kevin had subjected him to and research notes that boys in particular may copy their father's behaviour[65]. All three children would have experienced the impact of Kevin's behaviour and we know that Angela and Kevin's daughter was experiencing mental health issues, which is an incredibly common response to childhood experiences of domestic abuse[66]. Angela disclosed how distressful it was for her to watch her children suffer, and in her conversations with her PLW she focused mainly on the impact Kevin's behaviour was having on them.

In a meeting with Angela's family, they told the author of the report how desperate Angela was to protect her children and they also expressed how happy she was that she had begun to repair her relationship with her eldest son in the months leading up to her death. The family fed back to the author of the report that all three children are coping remarkably well, and that Angela would have been very proud of them.

However, we know that experiencing domestic abuse as a child often leads to lifelong trauma and health implications for victims and these can exist well into adulthood[67]. It is therefore vital that services respond rapidly to the needs of children living with abusive parents. As the IMR report for CSC suggests not all referrals regarding the children were made to them and this highlights a need to ensure that safeguarding for the impact of psychological trauma on childhood victims of domestic abuse are paramount.

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64 https://static1.squarespace.com/static/5ee0be2588f1e349401c832c/t/61826677bdb3b572a7350941/1635935884071/Shadow_Pandemic_Report+FINAL+%282%29.pdf

65 https://www.womensaid.org.uk/information-support/the-survivors-handbook/children-and-domestic-abuse/#1447860107135-3398d40a-e67d

66 https://www.womensaid.org.uk/the-survivors-handbook/children-and-domestic-abuse/

67 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3869039/

Angela's three children all had a diagnosis of neurodivergence. Being a single mother of three children with special needs would have been very stressful for her. From speaking to her family, we know that Angela vociferously advocated for agencies to respond to her children's extra needs appropriately. Angela's Mum told the author of the report that Angela researched the needs of neurodivergent children so well that the school made permanent changes to their processes and interventions for all children with a neurodivergent issues within the school system. The intersecting needs of a victim of domestic abuse who is also the primary carer of three children with special needs does not appear to have been noted in depth with agencies dealings with Angela. Experts note that children on the autism spectrum often have difficulty talking about any traumatic experience they may have had[68], they also need specific responses in terms flagging their experiences to professionals[69].

The Home Office Quality Assurance (QA) panel noted that the experience of domestic abuse that Angela's children were subjected to were 'unseen' and 'unheard', they further commented that this was particularly concerning because of their diagnosis of neuro divergence, and the impact of DVA on them being poorly understood. The panel agree with this assertion, and we can see from Angela's sisters' testimony, in section 11.9 below, that it was Angela who blamed herself for the impact Kevin's behaviour had on her children, and Kevin used this as a means of psychological abuse against her.

Studies have shown that individuals with neurodivergent conditions are at increased risk of domestic abuse[70]; with significantly higher rates for girls with ADHD[71]. It is important for professionals to understanding the intersections between neurodivergent people and the impact that domestic abuse has on them. Neurodivergent children hear 20,000 more negative comments per day than their peers aged 12[72], and combined with the emotional regulation challenges neurodivergent individuals have this results in an opportunity for perpetrators to further manipulate them.

The impact on neurodivergent children subjected to violence and abuse in the home is clear:

> *"Children with neurodevelopmental impairments/conditions appear to be at higher risk than their nondisabled peers of all forms of violence, including abuse and neglect by parents/carers, peers and others."*[73]

[68] https://www.kennedykrieger.org/stories/potential-magazine/fallwinter-2019/identifying-trauma-children-autism
[69] https://www.autismspeaks.org/recognizing-and-preventing-abuse
[70] https://www.linkedin.com/pulse/breaking-silence-understanding-intersection-neurodivergence/
[71] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1934403/
[72] https://www.linkedin.com/pulse/breaking-silence-understanding-intersection-neurodivergence/
[73] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/252659/33571_2901304_CMO_Chapter_9.pdf

A 2019 study[74] exploring children's negative life experiences and the links between anxiety and depression, reported 79% of children with autism disclosed *'a child or adult has humiliated, embarrassed, or scared me'*, compared to 52% of their peers.

The panel note that non-abusive parents like Angela, who are seen to be 'coping' and are vociferous advocates of their own children may result in agencies taking a step back from detailed interventions. This may be even more prevalent where children have additional needs, particularly because a supportive parent may understand the neurodivergent child's challenges in communicating. Professionals must be alert to neurodivergent children and the impacts of domestic abuse on them, in the same way they are with other learning needs and or disabilities.

11.9 Victim/Family Voice:

Towards the end of the process the author of the review was contacted by Angela's sister, the meeting was highly beneficial and the last words of the analysis in this report will be reserved for Angela and her family:

> *Angela was so clever and passionate, and incredibly strong minded. She was so creative, loving and kind, and would help anyone in need, but nobody helped her. She reached out so many times for support from so many different agencies and she just kept getting knocked back.*
>
> *She did so much independently that others would have relied on other people to do. For the divorce she was completely on her own, she was on benefits but owned a house so was not intitled to legal aid, even though she could never get at any of those assets from the property. In the end she didn't spend a penny on the divorce and navigated the whole system on her own. She didn't get any support from anyone.*
>
> *With regards to her mental health, she knew what type of support she needed, and she asked many times for specific counselling focused on her PTSD and trauma, she was reaching out to online support groups, she didn't drink, she didn't smoke, she did yoga. She tried everything to support her own mental health, and she knew she needed PTSD support because of the cyclical nature of how these thoughts would get stuck in her head.*
>
> *She and I suspected she had undiagnosed ADHD, but part of the problem of admitting to herself and others in getting support for that was she was just hugely fearful that it meant that Kevin was right, that she was "mad". The way he played into her brain was that if there was any chink of mental insecurity, he would attack her for it. This was a man who used the fact she took HRT as a slur to say she was "on drugs" and he tried to use that as a weapon against her. She was only on anti-depressants for three days and I don't think anyone appreciates how hard that was*

[74] https://www.westyorks-ca.gov.uk/media/8513/report-neurodiversity-and-violence.pdf

for her to do, she didn't believe in that kind of medication, so things must have been really bad. I think for her that was also an indication that it was her, that there was something wrong with her and she wasn't seen face to face for that appointment it was just a chat on the phone. She was dealing with a level of trauma built up over years that most people would collapse under.

For Angela it was never one thing, it was so many things but the current theme throughout was Kevin. Those were her last thoughts. In the end Kevin sold her the idea that he has moved on and was having a great life, which was all an illusion designed to make her feel bad, and it worked. She felt like it was because of her, that she was the problem. Angela felt she wasn't doing a good enough job as a Mum as her children were being so badly affected by Kevin's behaviour.

If Angela ever tried to move on Kevin would always interfere with what she was doing. He wore her down to a sense of worthlessness, there was no value in what she did. If she tried to work, she would be "neglecting the kids", and Kevin would say all these things whilst not financially supporting the children. But she was so resourceful, she made her benefits last and was never in debt, trying to convince her that this was a skill was really hard because he had worn her down so much. Ultimately, she was desperate to retrain professionally - she was doing her own counselling course and she really wanted a career of her own.

Angela was a fantastic Mother. The children's needs were hard to cope with on her own, and it was all because of their diagnoses, but Kevin would accuse her of having Munchausen's by proxy and deny their needs. He would make out that it was all made up because Angela was "mad". All these things built up in her head and she saw herself as a failure, but everything she was experiencing was completely out of her control, and she was so alone with them.

Angela reached out to the domestic abuse agency, but she didn't get much from them, she was just referred to counselling in the end but then there was no counselling there for her. Beyond getting out of the situation, where she did get some support, she was left to it.

The stalking and hacking of her social media was something that really upset her, she went to the police with it, and they wouldn't do anything with it. They didn't take it seriously at all as far as Angela was concerned. The thing is that Kevin has no respect for the criminal justice system, he still behaves in ways that show us as a family that he has no remorse, so when agencies don't take stuff seriously it just tells victims that perpetrators can keep getting away with it.

Although she didn't carry on reporting to the police Kevin was still very much perpetrating abuse and this was largely financial and through the family courts. Whatever courses Kevin went on for his behaviour they didn't work. Ironically, he now says he is having counselling for PTSD. Everything he says now paints him

as the victim. He isn't. The children and Angela are the victims. I can see an insight and the tactics he used with Angela now being directed at us as a family.

Angela should have had specific counselling for PTSD, she has three children with special needs and was going through the menopause and had experienced long term domestic abuse and was struggling with finances. There was no support for her when she was going through the family courts, and I think victims who have to navigate that system themselves should be guided in practical ways by domestic abuse agencies. Not only are victims like Angela having to deal with an archaic and complicated system but they are also having to deal with the abuse at the same time.

Angela and I wanted to set up a charity together to help women after domestic abuse. To help women move on and get them back into the career's they wanted to be in whilst also having counselling to suit their needs, there is nothing out there like that, everything is geared towards getting victims out of the situation but very little is there for afterwards when women want to rebuild their lives.

Her last words were, "I just can't feel a future, I just can't feel it." She shouldn't have had to feel like that because she tried so hard to survive. She needed professional help, and she deserved it.

I miss my sister terribly, she could create magic, and now she is gone.

12. Equality Act 2010

The Equality Act 2010 defines the following as protected characteristics:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

All IMR authors were tasked with considering the protected characteristics in the support and services afforded to Angela. Services must adhere to the Public Sector Equality Duty[75] and have due regard to the protected characteristics of individuals in order to harmonise equalities and foster good relations.

[75] https://www.equalityhumanrights.com/en/corporate-reporting/public-sector-equality-duty

There are generally three aims[76] under the PSED and these involve:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

No IMR authors raised the issue of the relevant protected characteristic of sex. Although the CCG noted Angela's 'gender' as relevant, 'gender' is not a protected characteristic, and has a different meaning than sex in legislation and policy. The protected characteristic applied to Angela's in this review is her sex, and this is important to note and analyse this.

The sex of a victim is relevant[77]. Females are disproportionately the victims of homicide in domestic abuse cases. According to new data released by the United Nations Office on Drugs and Crime (UNODC), research shows that an average of 137 women across the world are killed by a partner or family member every day, the research further evidence that 58% of women who are murdered, are murdered by a partner or family member[78]. In addition, through the work of Karen Ingala Smith[79], we know that in the UK 1,425 women have been murdered by men over the ten-year period between 2009 and 2018[80]. That equates to one woman being murdered every three days by a man and one woman every four days by a man she knows. Angela shares many of the same experiences as the other women murdered, although their protected characteristics may differ in some respects, the one characteristic they all share is their biological sex.

In addition, we know through research[81] that death rates from suicide are consistently higher for men, and thus many interventions to reduce the suicide rate amongst populations are aimed at men. Although this good work should not be undermined, it means that women's experience of suicidal ideation is often side-lined. Given that women are significantly more likely than men to attempt suicide[82], responding to women's suicidal ideation should also be a priority:

> *The role of traumatic experiences, such as being subjected to domestic abuse, as a precursor to suicidality has already been formally recognised at national (Department of Health, 2012) and international (WHO, 2014) levels. However, the scale, dynamics and complexity of this intersection, and the ways in which*

[76] https://www.equalityhumanrights.com/en/corporate-reporting/public-sector-equality-duty
[77] https://bristoluniversitypressdigital.com/view/journals/jgbv/6/3/article-p535.xml
[78] https://www.bbc.co.uk/news/world-46292919
[79] https://kareningalasmith.com/counting-dead-women/
[80] https://www.femicidecensus.org/wp-content/uploads/2020/11/Femicide-Census-10-year-report.pdf
[81] https://journals.sagepub.com/doi/full/10.1177/0269758018824160
[82] https://journals.sagepub.com/doi/full/10.1177/0269758018824160#bibr15-0269758018824160

positive interventions may be secured, remain significantly under-researched, particularly in the UK.[83]

Women's experiences of suicide need to be featured and prioritised within research, particularly within the context of domestic abuse. Failure to prioritise resources for female victims' experiences of suicide does not pay due regard to their protected characteristic of sex. If services and responses for suicide reduction are aimed at men, women are indirectly discriminated against.

The panel make further multi-agency and national recommendations in response to these aspects.

13. Key Findings

13.1 Training and Review of Processes:

A number of training needs were identified within the analysis. The identifiable points included professional's knowledge gaps in understanding of the crime of stalking and the issues for victims. Similarly, Kevin's coercive and controlling behaviour was a feature that was not routinely explored with Angela. The subsequent impact on a victim's wellbeing and mental health needs to be understood better in order to safeguard them from any harm.

In addition to the above the DASH risk assessment form was identified by the panel to be used in silo by organisations, DASH's were completed with Angela and then re-done without any reference to the previous risk score or disclosures, sometimes the DASH was re-done within hours with Angela. Notwithstanding the needless repetition for professionals here, the trauma it may cause a victim to have to keep repeating their story in the same way to professionals cannot be underestimated. It would be perfectly reasonable for victims to lose trust in the process of the DASH if it is not undertaking correctly or if the process becomes too bureaucratic.

In order for training to be effective there needs to be a system of review for the outcome of knowledge increase in professionals, alongside these processes and systems must aid professionals rather than block them from ensuring victims of domestic abuse are getting the best support.

13.2 Trauma Informed Practice

Trauma informed practice is becoming increasingly understood as the meaningful way to engage victims and survivors. Throughout the analysis the need to embed trauma informed practice across all agencies was highlighted. This is particularly important to understand when reflecting on Angela's death by suicide, and the gaps in knowledge for professionals were noted by the QA panel.

13.3 Health Responses

[83] https://journals.sagepub.com/doi/full/10.1177/0269758018824160

Overall, the response from Angela's GP practice was very good. However, there is learning to be gathered from the review of Angela's situation. Routine screening by health professionals is one of the most effective ways to engage victims[84]. This should not just fall onto GPs but as highlighted other departments like the Minor Injuries Unit should routinely ask the question of whether patients are experiencing DVA.

In addition to this the knowledge around the impact of domestic abuse on menopausal women is a growing area and health professionals need to keep abreast of the emerging data in this area of academic research.

Similarly, to trauma informed practice, empathetic curiosity of victims by health professionals can foster further discussions around any suicidal ideation the victim may have.

13.4 Information Sharing

Information sharing is often the key to ensuring better outcomes of victims and their children. In the above analysis the IMR authors within children's social care and Avon and Somerset police were able to highlight the developments needed to ensure a more robust system of referral routes after incidents of domestic abuse. In addition, gaps were identified in the Probation Service and SIDAS in liaising with Children's Social Care. Much of the above has been rectified and the panel were encouraged to see that changes were already underway.

The issue of Angela's case not being heard at MARAC on three separate occasions highlights a concern that will need to be addressed robustly in a coordinated response from the Safer Somerset Partnership.

13.5 DA Advocacy Services

The independence and robust way in which Domestic Abuse Services advocate for their clients is one of the most important interventions a victim can have. Throughout the review the panel felt the pro-active way in which Angela repeatedly tried to seek support was not responded to in the way in which an independent DA service would be expected to.

Short interventions and an onus on Angela to change her situation with little support were apparent. Some of the issues within the SIDAS service link to other findings, however there were particular situations where Angela was expected to advocate for herself, sometimes with SIDAS themselves. These main issues were:

- An onus on Angela to get a non-molestation order from an organisation who is not local and can cost victims financially.
- SIDAS closing Angela's case shortly after the MARAC noted they were offering support.
- Angela requesting support at a CSC meeting, and none was provided.

Navigating the intervention of lots of different agencies whilst simultaneously experiencing domestic abuse is a very difficult space to be in. An independent

[84] http://irisi.org/

domestic abuse organisation is the place that victims should be able to go to in order to carry some of the burden until the violence and abuse decreases or stops. The QA panel noted the swift closure of Angela's case, despite the escalation of risk increasing against her.

13.6 COVID19 Pandemic

The full impact of the COVID19 pandemic on domestic abuse victims and the services that support them is yet to be understood. Alongside this, and intertwined with it, was a devastating impact on victims of domestic abuse, as support networks were cut off, and the 'shadow pandemic' left people trapped at home with their abuser or with an ex-partner who knew how to access them easily.

Research details:

> *"COVID acted as an escalator and intensifier of existing abuse in individual cases. Victims have been less able to seek help or advice. In some cases, victims' access to ongoing support or help with caring responsibilities or mental or physical health conditions have been reduced. Furthermore, vulnerable children and adults have in some cases been made more 'invisible' to services through home-schooling and homeworking. Both victims' and suspects' ability to manage mental ill-health and drug/alcohol dependencies have been reduced by the pandemic[85].*

During the pandemic research also revealed the increase in risk to victims of stalking. Social isolation and lack of trust in other forms of communication because of stalkers behaviours, were exacerbated for victims and increased the impact on their mental health outcomes[86].

The panel agree that agencies did the best they could at an unprecedented time, but it is important to continue to reflect and learn from the pandemic, especially as health concerns grow globally and we have an ageing population.

13.7 Domestic Abuse and the Links with Suicidal Ideation

The increase in knowledge of the links between domestic abuse and suicidal ideation is a growing area of expertise. The work in this area has often been overlooked and it is now emerging that:

- Women who have experienced abuse from a partner are three times more likely to have made a suicide attempt in the last year (compared to those who have not experienced abuse).
- Women living in poverty are especially at risk

[85] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1013128/Domestic_homicides_and_suspected_victim_suicides_during_the_Covid-19_Pandemic_2020-2021.pdf

[86] https://link.springer.com/article/10.1007/s10896-020-00201-0

- Sexual abuse puts victims at raised risk of self-harm, suicidal thoughts and suicide attempts[87]

Angela had experienced all of the above and it is imperative that professionals are better supported to understand the links between domestic abuse and suicide to better safeguard victims.

13.8 Children and Domestic Abuse

The panel note that a more holistic understanding of the needs of children and young people experiencing domestic abuse should be considered, in addition it is imperative that professionals are alert to the intersections of children with neurodivergence and the support required for the non-abusive parent caring for them. The QA panel further noted that the experience of Angela's children appeared to be 'unseen' and 'unheard', and professionals lacked the capacity to understand the impact that DA would have on neurodivergent children.

14. Recommendations

Paying due regard to the key findings and analysis above the recommendations and subsequent action plan are offered by the panel.

The panel agreed all single agency actions out forward by IMR authors (reflected in the action plan - Section 15). The panel have provided actions where they felt there were gaps for each agency. In addition, the panel have agreed the following multi-agency recommendations for the Somerset area.

14.1 Multi-Agency* Actions

Training

- Using Angela's experience as a case study combine the key findings from this review and the other similar reviews in Somerset, and produce a webinar for discussion, learning and interaction in multi-agency training. Angela's sister to be involved in the webinar development, user involvement developments, and feature in any training if she feels able.
- Re-promotion of the commissioned SIDAS multi-agency training for the agencies incorporated within this review, to increase the awareness for professionals on the crime of stalking and Coercive and Controlling Behaviour, including a focus on tech-facilitated abuse.
- Design and promote a leaflet including resources from Surviving Economic Abuse, to promote awareness of the issue of economic abuse, ensure information on access to specialist support on these issues, e.g., Via SIDAS and Citizens Advice Bureau (CAB). (This recommendation was provided by Angela's family).

[87] New Figures Reveal Link Between Suicidal Thoughts and Domestic Abuse - Agenda Alliance

- CSP to promote children's status as victims in the DA Act[88], and continuing promoting the services available via SIDAS for children and young people experiencing domestic abuse.
- Training for SIDAS, to support parents of children with neurodivergence.
- CCG to incorporate learning from the emerging field of academic and practitioner understanding, on the impact of DA on menopausal women. Although focused on health professionals learning via leaflets/newsletters should also be extended to multi-agency partners to expand the knowledge for other professionals on this growing body of research.
- Specialist training for Avon and Somerset Constabulary on stalking and harassment to be commissioned.

Review of systems and knowledge

- The Safer Somerset Partnership to undertake a review of the pathway for victims and where systems and or required processes within agencies may hinder professionals from effective use of professional judgement, for example with the DASH.
- Avon and Somerset police to continue to monitor the use of DARA nationally and implement any learning within the force and feedback to the Somerset Community Safety Partnership.
- SIDAS to adopt the use of Screening Assessment for Stalking and Harassment (SASH)[89] in all cases where stalking may be a feature of the risk to a victim.
- Primary Care and Emergency Departments to review and promote the use of routine screening across all departments on a rolling basis, using the interaction between the GP and Angela as a benchmark of good practice.
- Agencies to report back to the Safer Somerset Partnership on the change implemented through training and or workforce development one year after the completion of the associated actions.
- SIDAS and CSP to provide information (on websites and through social media platforms) for victims navigating the family court system including for those who have no access to legal aid e.g., via Rights of Women[90] and Shera[91] (this recommendation was provided by Angela's family).
- The Education sector in Somerset to better support professionals within Education to be involved in Domestic Homicide Reviews, including via detailed IMR submissions and presence on panels.

Suicide and Domestic Abuse

[88] https://www.legislation.gov.uk/ukpga/2021/17/enacted
[89] https://www.stalkingriskprofile.com/stalking-risk-profile/sash
[90] https://rightsofwomen.org.uk/further-help/
[91] https://www.shera-research.com/resource-category/family-court-resources

- Multi-agency training for professionals to understand the link between DA and suicide – consideration of the use of Professor Jane Monkton-Smith's suicide timeline[92] as her research and work in this area progresses.
- In addition to multi-agency training, the Safer Somerset partnership to conduct analysis via a snapshot of data from all local DHRs into the resources needed to support women who are experiencing DVA where suicidal ideation may be a feature. The aim of this is to ensure appropriate interventions are commissioned in the future and the recommendations from the recent Agenda Alliance research is embedded where appropriate.
- Somerset Council and the ICB to undertake a mapping of a) availability of specialist counselling and b) what work is happening strategically. Then subsequently develop an action plan to progress next steps in ensuring there's availability or clarity of how people can access counselling services.

MARAC/ Information Sharing

- Safer Somerset Partnership to seek assurance that the revised MARAC Process (commenced 01/10/2022) is effective and robust in providing risk management for high-risk victims of domestic abuse and that any rejection to hear a MARAC case is routinely recorded and shared with all multi-agency partners attending MARAC meetings.
- Safer Somerset CSP to ensure multi-agency partners agree a lead professional in cases of domestic abuse, this can either be done via the MARAC process or through SIDAS/CSC where cases do not meet the MARAC threshold.

Trauma Informed Practice

- The Safer Somerset partnership to explore the expansion of trauma informed practice for multi-agency partners involved in this review, including in policies, training and in the requirements and benchmarks of commissioning.

*Multi-agency refers to all partners who were involved in the panel and any further stakeholders the CSP think are pertinent.

14.2 National Recommendations

The Home Office QA panel agreed with the national recommendations set out below but did question the ability to implement all of them. The panel have amended where necessary and incorporated previous national recommendations for Education into the multi-agency section above, with the expectation that this will be more achievable.

The panel assert that in order to change the landscape of fatal deaths relating to domestic abuse DHRs need to be aspirational. Nonetheless following the QA panel's comments some recommendations below have been amended to ensure the best possible chance of implementation.

[92] https://eprints.glos.ac.uk/10579/16/10579_Monckton-Smith_%282022%29_Home_Office_Report.pdf

- A reminder to local authorities of the use of a full combined chronology report which should be given to review chairs and authors.
- The panel recommend a copy of this review is sent to Umbrella bodies that offer accreditations to DA services, for example, SafeLives and Women's Aid. Following this they should explore an option to support services with Leading Lights accreditation or Women's Aid National Quality Standards when a DHR occurs, at no extra cost to the frontline provider. The aim would be to facilitate a review into the content of the work undertaken and support staff after the death of a victim. Any review should move away from process and KPI's that are often the focus of Umbrella bodies accreditation and focus on the support and work done with victims.
- The panel recommend that SafeLives develop a standard practice of advising professionals via their training programmes to inform victims what the outcome of the grading of the DASH risk assessments and encourage them to tell other professionals where they are able to. This will then increase empowerment and information sharing on risk factors, and inevitably foster increased context for each assessment undertaken, thereby reducing incorrect and siloed grading on each incident.
- Training and undergraduate level knowledge in Trauma Informed Responses should be adopted across police forces, and in Health and Social Care in England and Wales. This should be started from basic training/graduate programmes and continued throughout the course of a professional's career.
- A copy of this review to be sent with the Centre for Women's Justice Super Complaint findings[93], to DCC Maggie Blythe (National Police Chief Lead for Violence Against Women and Girls) and Alison Saunders (Director of Public Prosecutions) to highlight the ongoing issues with powers designed to protect victims of domestic abuse, including restraining orders.
- The DA Commissioners office to commission a review of the risk assessment processes undertaken with victims and survivors of Domestic Abuse across multi-agency partners. The aim of the review would be to ensure risk assessments are effective, evidence based, and undertaken for the benefit of the victim's safeguarding.
- The DA Commissioner to commission research and present the data retained in the Home Office DHR Repository for victims of suicide, with a view to enabling local areas to understand the needs of victims better and reduce the harms caused by domestic abuse and the links to suicide in females.
- The Domestic Abuse Commissioner to promote Agenda Alliance research and recommendations into the links between Domestic Abuse and suicidal thoughts via the DA commissioner's newsletter and social media platforms[94]

[93] https://static1.squarespace.com/static/5aa98420f2e6b1ba0c874e42/t/5c91f55c9b747a252efe260c/1553069406371/Super-complaint+report.FINAL.pdf

[94] New Figures Reveal Link Between Suicidal Thoughts and Domestic Abuse - Agenda Alliance

15. Action Plan – see attached

16. Appendices

Appendix A

TERMS OF REFERENCE FOR REVIEW PANEL
DHR 045

1. Introduction

1.1 The chair of the Safer Somerset Partnership has commissioned this DHR in response to the death of ***. The death is believed to be suicide, with the person causing harm being her ex-partner.

1.2 All other responsibility relating to the review commissioners (Safer Somerset Partnership) namely any changes to these Terms of Reference and the preparation, agreement and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Partnership.

2. Aims of The Domestic Homicide Review Process

2.1 Establish the facts that led to the death in January 2022 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family

2.2 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

2.3 To produce a report which:

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

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

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

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

3. Scope of the review

The review will:

- Consider the period from 01.01.208 to 22.01.2022, subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events that are relevant.
- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Domestic Violence Crime and Victims Act (2004), and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events. Taking account of 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 victim or her family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
    - Against the Equality Act 2010's protected characteristics.
    - In regards to children and pregnancy and any potential impact this had ensuring the safeguarding of any children during the review.

- Examine the events leading up to the incident, including a chronology of the events in question.

- 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. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

Appendix B

Home Office Quality Assurance Letter

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Suzanne Harris
Senior Commissioning Officer (Interpersonal Violence)
Somerset County Council
Maltravers House, Petters Way
Yeovil
BA20

21st December 2023

Dear Suzanne,

Thank you for submitting the Domestic Homicide Review (DHR) report (Angela) for Somerset Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 22nd November 2023. I apologise for the delay in responding to you.

The QA Panel agreed that the review was thorough, thoughtful and overall effectively captured key points. There was positive engagement with Angela's family and friends who participated in the review. The chair liaised with Angela's parents on including the children in the review process, although it was assessed that it would not be in their best interest at the time, it was positive that their views/voices were considered.

There was positive engagement with GP service, particularly when Angela made her first disclosure of DA, the GP evidenced professional curiosity regarding impact on Angela and children, undertook some basic safety planning with Angela, discussed DA services (SIDAS) and made a referral to Children Social Care (CSC).

There was good use of research within the report and the QA panel appreciated that the author drew connections between other DHRs, to demonstrate repeated learning.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- The QA panel highlighted the present tense used in the chronology as problematic, knowing Angela is deceased. They also highlighted that there are some typos and spelling errors throughout the report.

- The QA panel raised queries on points - 9.1 – *it would be helpful to explain what this is about as this is common practice.* And 9.8 – *Was he cautioned for an offence or charged and convicted or pleaded guilty later at court? What was the outcome in court in terms of the sentence?*

- The QA panel felt that the children's experiences of domestic abuse were unseen and unheard, which they found particularly concerning as the three children were neurodivergent, and therefore the impact may have been poorly understood.

- The QA panel agreed that it would have been helpful to have had a representative from education on the panel, especially considering the individual management review (IMR) issues identified in the review. This would have helped to provide an insight to any issues the children were experiencing around domestic abuse.

- The QA panel felt there was a lack of a trauma-informed care approach to Angela and a lack of joined up approached to the number of DASH's that were completed. There was also a swift discharge from DA services, despite her continuing to experience escalating issues of DA.

- The QA panel felt the report could have gone into further detail in relation to gaps in agency knowledge – there could have been greater emphasis on the tech-facilitated abuse Angela experienced, which was dismissed by officers. The need for greater understanding of the ways in which technology can be used in myriad subtle ways to control and abuse, long after separation, could have been highlighted more.

- The QA panel supported many of the national recommendations made, however noted concern on viability to implement all of them.

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

Domestic Homicide Review

Executive Summary

Somerset

Community Safety Partnership

Report into the death of Angela

January 2022

Author – Dr Shonagh Dillon, LLB, DCrimJ

May 2023

1. Executive Summary

The independent author, DHR panel and the Safer Somerset Partnership wish to offer their deepest condolences to everyone who was affected by Angela's[95] death. We extend our further thanks to Angela's family for contributing to this review, their generosity in doing so, considering their loss, is greatly appreciated.

1.1 Summary

Angela and Kevin[96] were in a relationship for 17 years and they had three children together. They moved from London to Somerset in 2003 and set up home with their first son. They subsequently had two more children another son and a daughter. All three children have an official diagnosis relating to neurodivergence.

Angela became pregnant within one month of her and Kevin meeting and from the outset Angela's family noted that Kevin was controlling. When talking to the chair of the panel, the family relayed an incident a friend of Angela's had recalled early on in Angela and Kevin's relationship. Kevin had come into the living room whilst they were chatting one day, he had barely spoken to Angela's friend and Angela had explained this was just how he was. Angela and her friend popped out of the house and when they came back Kevin had cut the wire to the Television to stop them from watching it.

Life was difficult for Angela with three small children with the compounding factors of coping with neurodivergence. Kevin continued to show abusive traits throughout the relationship and Angela often wondered if he also had neurodivergent or had mental health issues. Angela expressed to her family that she really wanted to make things work with Kevin, but his behaviour became worse and progressively more violent and controlling.

In 2018 Angela began to seek help from external agencies for the domestic abuse she was experiencing, at this stage she still wanted things to work between her and Kevin, but escalating events led her to leave Kevin in late 2018. Throughout the following years until her death Kevin continued to be abusive towards Angela, resulting in four convictions for physical assaults and a continued course of persistent stalking and harassment ensued. Angela's sister explained to the review author that Angela was incredibly proud that she never returned to Kevin after leaving him. Although life was a struggle every day, Angela knew that what Kevin had done to her was abusive.

From the detail below we can see that Angela was very proactive in seeking support from various different agencies in relation to the domestic abuse. Kevin continued his behaviour and Angela's stresses were exacerbated by financial issues and being a single Mother to three children with special needs.

In January 2022 Angela died by suicide.

It is the view of the panel, the chair and most importantly Angela's family that her life is honoured within this review, so that lessons can be learned, and Angela's

[95] Not her real name
[96] Not his real name

experience of the system and organisations, can lead to change for other victims of domestic abuse.

The family wished for this poem to be represented in the review as a tribute to Angela:

> *"She was beautiful, but not like those girls in magazines.*
>
> *She was beautiful, for the way she thought.*
>
> *She was beautiful, for the sparkle in her eyes when she talked about something she loved.*
>
> *She was beautiful, for her ability to make other people smile, even if she was sad.*
>
> *No, she wasn't beautiful for something as temporary as her looks. She was beautiful, deep down to her soul. She is beautiful." F. Scott Fitzgerald*

1.2 Domestic Homicide Reviews

1.2.1 The referral from Somerset NHS Foundation Trust was sent to the CSP on 31st January 2022. The decision to undertake a DHR was made by Safer Somerset Partnership (CSP) on 5th March 2022. The Home Office was subsequently informed. On 6th April 2022 the CSP commissioned Dr Shonagh Dillon to undertake the role of independent author and chair to the panel and the DHR panel was convened. All meetings took place virtually.

1.2.1 Domestic Homicide Reviews (DHRs) came into force on the 13th of April 2011.They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004).

The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

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

(b) A member of the same household as herself; with a view to identifying the lessons to be learnt from the death[97].

1.2.3 The purpose of a DHR is to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

[97] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office - December 2016

b) 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;

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice

1.3 Terms of Reference

1.3.1 The specific aims of the review were identified as follows:

- 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 learned from the case about the way in which local professionals and agencies worked together to support or manage the person who caused harm.

1.4 Independence

1.4.1 The author of this report, Dr Shonagh Dillon, was independent of all agencies involved in the panel. She had no previous dealings with the initial inquiries and no contact or knowledge of the family members.

1.4.2 Additionally, all IMR authors and Panel members were independent of any direct contact with the subjects of this DHR. None of the panel members were the immediate line managers of anyone who engaged with Angela or Kevin.

1.5 Parallel Reviews

1.5.1 There were no other parallel review processes arising from Angela's death.

1.6 Methodology

1.6.1 Following the decision to conduct this DHR, Avon and Somerset Police provided the panel with a timeline of the case. Subsequently, several other statutory and voluntary sector agencies were asked to return a summary of their involvement to help the panel understand and analyse any interactions they had with Angela and Kevin during the specified review period.

Having considered the summaries, the following Individual Management Reviews (IMRs) were requested:

h) Avon and Somerset Police
i) Somerset NHS Foundation Trust
j) Children's Social Care
k) National Probation
l) Somerset Independent Domestic Abuse Service (SIDAS)
m) Education
n) Somerset ICB

1.6.2 The DHR panel consisted of the following agencies and professionals:

Job Title/ Agency	**Name**
Independent Chair and Author	Dr Shonagh Dillon
Senior Commissioning Officer (Interpersonal Violence) Somerset County Council	Suzanne Harris
Domestic Abuse Expert (Paragon Regional Manager)	Jayne Hardy
Named Professional for Safeguarding Adults / Prevent Lead	Heather Sparks
Designated Nurse for Safeguarding Adults NHS Somerset Safeguarding Team	Julia Mason
Detective Inspector Major Statutory Crime Review Team	Su Parker
Head of Service, Probation Service Somerset	Liz Spencer
Operations Manager First Response, Early Help Hub	Kelly Brewer

and EDT (Children's Social Care)	

1.6.3 The chair would like to thank all professionals involved in this review, their time, effort and cooperation was exemplary.

1.7 Contact with Family and Friends

The chair of the panel initially wrote to Angela's family members in July 2022 – despite their continued distress at their loss - Angela's parents were incredibly gracious in contacting the chair, who they initially met via video link in August of 2022. The Chair and Angela's Mother continued to communicate via email over the course of the review.

The decision was made following discussions with Angela's family not to meet with her children. Angela's family felt that being involved in the review at this stage in the children's lives would be incredibly stressful for them. It was agreed with the family that the review author would send the published report to them so that, should the children wish to read the contents of the review in the future, they can do so with family support.

Just prior to the end of the review process, Angela's sister got in contact with the chair of the panel, and they met in March 2023.

The panel deliberated on whether to contact Kevin as part of this review. The panel undertook a full risk assessment with the intelligence that was available to them and decided against contacting Kevin.

After speaking with Angela's sister, the review author confirmed that the panel had made the correct decision in not contacting Kevin.

The report is therefore limited in the response and thoughts of the perpetrator in this case.

1.8 Key Findings

1.8.1 Training and review of processes:

A number of training needs were identified within the analysis. The identifiable points included professional's knowledge gaps in understanding of the crime of stalking and the issues for victims. Similarly, Kevin's coercive and controlling behaviour was a feature that was not routinely explored with Angela. The subsequent impact on a victim's wellbeing and mental health needs to be understood better in order to safeguard them from any harm.

In addition to the above the DASH risk assessment form was identified by the panel to be used in silo by organisations, DASHs were completed with Angela and then re-done without any reference to the previous risk score or disclosures, sometimes the DASH was re-done within hours with Angela. Notwithstanding the needless repetition for professionals here, the trauma it may cause a victim to have to keep repeating their story in the same way to professionals cannot be underestimated. It would be perfectly reasonable for victims to lose trust in the process of the DASH if it is not undertaking correctly or if the process becomes too bureaucratic.

In order for training to be effective there needs to be a system of review for the outcome of knowledge increase in professionals, alongside these processes and systems must aid professionals rather than block them from ensuring victims of domestic abuse are getting the best support.

1.8.2 Trauma Informed Practice

Trauma informed practice is becoming increasingly understood as the meaningful way to engage victims and survivors. Throughout the analysis the need to embed trauma informed practice across all agencies was highlighted. This is particularly important to understand when reflecting on Angela's death by suicide, and the gaps in knowledge for professionals were noted by the QA panel.

1.8.3 Health Responses

Overall, the response from Angela's GP practice was very good. However, there is learning to be gathered from the review of Angela's situation. Routine screening by health professionals is one of the most effective ways to engage victims[98]. This should not just fall onto GPs but as highlighted other departments like the Minor Injuries Unit should routinely ask the question of whether patients are experiencing DVA.

In addition to this the knowledge around the impact of domestic abuse on menopausal women is a growing area and health professionals need to keep abreast of the emerging data in this area of academic research.

Similarly, to trauma informed practice, empathetic curiosity of victims by health professionals can foster further discussions around any suicidal ideation the victim may have.

1.8.4 Information Sharing

[98] http://irisi.org/

Information sharing is often the key to ensuring better outcomes of victims and their children. In the above analysis the IMR authors within children's social care and Avon and Somerset police were able to highlight the developments needed to ensure a more robust system of referral routes after incidents of domestic abuse. In addition, gaps were identified in the Probation Service and SIDAS in liaising with Children's Social Care. Much of the above has been rectified and the panel were encouraged to see that changes were already underway.

The issue of Angela's case not being heard at MARAC on three separate occasions highlights a concern that will need to be addressed robustly in a coordinated response from the Safer Somerset Partnership.

1.8.5 DA Advocacy services

The independence and robust way in which Domestic Abuse Services advocate for their clients is one of the most important interventions a victim can have. Throughout the review the panel felt the pro-active way in which Angela repeatedly tried to seek support was not responded to in the way in which an independent DA service would be expected to.

Short interventions and an onus on Angela to change her situation with little support were apparent. Some of the issues within the SIDAS service link to other findings, however there were particular situations where Angela was expected to advocate for herself, sometimes with SIDAS themselves. These main issues were:

- An onus on Angela to get a non-molestation order from an organisation who is not local and can cost victims financially.
- SIDAS closing Angela's case shortly after the MARAC noted they were offering support.
- Angela requesting support at a CSC meeting, and none was provided.

Navigating the intervention of lots of different agencies whilst simultaneously experiencing domestic abuse is a very difficult space to be in. An independent domestic abuse organisation is the place that victims should be able to go to in order to carry some of the burden until the violence and abuse decreases or stops. The QA panel noted the swift closure of Angela's case, despite the escalation of risk increasing against her.

1.8.6 COVID19 Pandemic

The full impact of the COVID19 pandemic on domestic abuse victims and the services that support them is yet to be understood. Alongside this, and intertwined with it, was a devastating impact on victims of domestic abuse, as support networks were cut off, and the 'shadow pandemic' left people trapped at home with their abuser or with an ex-partner who knew how to access them easily.

Research details:

> *"COVID acted as an escalator and intensifier of existing abuse in individual cases. Victims have been less able to seek help or advice. In some cases, victims' access to ongoing support or help with caring responsibilities or mental*

or physical health conditions have been reduced. Furthermore, vulnerable children and adults have in some cases been made more 'invisible' to services through home-schooling and homeworking. Both victims' and suspects' ability to manage mental ill-health and drug/alcohol dependencies have been reduced by the pandemic[99].

During the pandemic research also revealed the increase in risk to victims of stalking. Social isolation and lack of trust in other forms of communication because of stalkers behaviours, were exacerbated for victims and increased the impact on their mental health outcomes[100].

The panel agree that agencies did the best they could at an unprecedented time, but it is important to continue to reflect and learn from the pandemic, especially as health concerns grow globally and we have an ageing population.

1.8.7 Domestic Abuse and the Links with suicidal ideation

The increase in knowledge of the links between domestic abuse and suicidal ideation is a growing area of expertise. The work in this area has often been overlooked and it is now emerging that:

- Women who have experienced abuse from a partner are three times more likely to have made a suicide attempt in the last year (compared to those who have not experienced abuse).
- Women living in poverty are especially at risk.
- Sexual abuse puts victims at raised risk of self-harm, suicidal thoughts, and suicide attempts[101]

Angela had experienced all of the above and it is imperative that professionals are better supported to understand the links between domestic abuse and suicide to better safeguard victims.

1.8.8 Children and Domestic Abuse

The panel note that a more holistic understanding of the needs of children and young people experiencing domestic abuse should be considered, in addition it is imperative that professionals are alert to the intersections of children with neurodivergence and the support required for the non-abusive parent caring for them. The QA panel further noted that the experience of Angela's children appeared to be 'unseen' and 'unheard', and professionals lacked the capacity to understand the impact that DA would have on neurodivergent children.

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99 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1013128/Domestic_homicides_and_suspected_victim_suicides_during_the_Covid-19_Pandemic_2020-2021.pdf

100 https://link.springer.com/article/10.1007/s10896-020-00201-0

101 New Figures Reveal Link Between Suicidal Thoughts and Domestic Abuse - Agenda Alliance

1.9 Recommendations

Paying due regard to the key findings and analysis above the recommendations and subsequent action plan are offered by the panel.

The panel agreed all single agency actions out forward by IMR authors (reflected in the action plan - Section 15). The panel have provided actions where they felt there were gaps for each agency. In addition, the panel have agreed the following multi-agency recommendations for the Somerset area.

1.9.1 Multi-Agency* Actions

Training

- Using Angela's experience as a case study combine the key findings from this review and the other similar reviews in Somerset, and produce a webinar for discussion, learning and interaction in multi-agency training. Angela's sister to be involved in the webinar development, user involvement developments, and feature in any training if she feels able.
- Re-promotion of the commissioned SIDAS multi-agency training for the agencies incorporated within this review, to increase the awareness for professionals on the crime of stalking and Coercive and Controlling Behaviour, including a focus on tech-facilitated abuse.
- Design and promote a leaflet including resources from Surviving Economic Abuse, to promote awareness of the issue of economic abuse, ensure information on access to specialist support on these issues, e.g., Via SIDAS and Citizens Advice Bureau (CAB). (This recommendation was provided by Angela's family).
- CSP to promote children's status as victims in the DA Act[102], and continuing promoting the services available via SIDAS for children and young people experiencing domestic abuse.
- Training for SIDAS, to support parents of children with neurodivergence.
- CCG to incorporate learning from the emerging field of academic and practitioner understanding, on the impact of DA on menopausal women. Although focused on health professionals learning via leaflets/newsletters should also be extended to multi-agency partners to expand the knowledge for other professionals on this growing body of research.
- Specialist training for Avon and Somerset Constabulary on stalking and harassment to be commissioned.

Review of systems and knowledge

- The Safer Somerset Partnership to undertake a review of the pathway for victims and where systems and or required processes within agencies may hinder professionals from effective use of professional judgement, for example with the DASH.
- Avon and Somerset police to continue to monitor the use of DARA nationally and implement any learning within the force and feedback to the Somerset Community Safety Partnership.

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

- SIDAS to adopt the use of Screening Assessment for Stalking and Harassment (SASH)[103] in all cases where stalking may be a feature of the risk to a victim.
- Primary Care and Emergency Departments to review and promote the use of routine screening across all departments on a rolling basis, using the interaction between the GP and Angela as a benchmark of good practice.
- Agencies to report back to the Safer Somerset Partnership on the change implemented through training and or workforce development one year after the completion of the associated actions.
- SIDAS and CSP to provide information (on websites and through social media platforms) for victims navigating the family court system including for those who have no access to legal aid e.g., via Rights of Women[104] and Shera[105] (this recommendation was provided by Angela's family).
- The Education sector in Somerset to better support professionals within Education to be involved in Domestic Homicide Reviews, including via detailed IMR submissions and presence on panels.

Suicide and Domestic Abuse

- Multi-agency training for professionals to understand the link between DA and suicide – consideration of the use of Professor Jane Monkton-Smith's suicide timeline[106] as her research and work in this area progresses.
- In addition to multi-agency training, the Safer Somerset partnership to conduct analysis via a snapshot of data from all local DHRs into the resources needed to support women who are experiencing DVA where suicidal ideation may be a feature. The aim of this is to ensure appropriate interventions are commissioned in the future and the recommendations from the recent Agenda Alliance research is embedded where appropriate.
- Somerset Council and the ICB to undertake a mapping of a) availability of specialist counselling and b) what work is happening strategically. Then subsequently develop an action plan to progress next steps in ensuring there's availability or clarity of how people can access counselling services.

MARAC/ Information Sharing

- Safer Somerset Partnership to seek assurance that the revised MARAC Process (commenced 01/10/2022) is effective and robust in providing risk management for high-risk victims of domestic abuse and that any rejection to hear a MARAC case is routinely recorded and shared with all multi-agency partners attending MARAC meetings.
- Safer Somerset CSP to ensure multi-agency partners agree a lead professional in cases of domestic abuse, this can either be done via the MARAC process or through SIDAS/CSC where cases do not meet the MARAC threshold.

[103] https://www.stalkingriskprofile.com/stalking-risk-profile/sash
[104] https://rightsofwomen.org.uk/further-help/
[105] https://www.shera-research.com/resource-category/family-court-resources
[106] https://eprints.glos.ac.uk/10579/16/10579_Monckton-Smith_%282022%29_Home_Office_Report.pdf

Trauma Informed Practice

- The Safer Somerset partnership to explore the expansion of trauma informed practice for multi-agency partners involved in this review, including in policies, training and in the requirements and benchmarks of commissioning.

*Multi-agency refers to all partners who were involved in the panel and any further stakeholders the CSP think are pertinent.

1.9.2 National Recommendations

The Home Office QA panel agreed with the national recommendations set out below but did question the ability to implement all of them. The panel have amended where necessary and incorporated national recommendations for Education into the multi-agency section above, with the expectation that this will be more achievable.

The panel assert that in order to change the landscape of fatal deaths relating to domestic abuse DHRs need to be aspirational. Nonetheless following the QA panel's comments some recommendations below have been amended to ensure the best possible chance of implementation.

- A reminder to local authorities of the use of a full combined chronology report which should be given to review chairs and authors.
- The panel recommend a copy of this review is sent to Umbrella bodies that offer accreditations to DA services, for example, SafeLives and Women's Aid. Following this they should explore an option to support services with Leading Lights accreditation or Women's Aid National Quality Standards when a DHR occurs, at no extra cost to the frontline provider. The aim would be to facilitate a review into the content of the work undertaken and support staff after the death of a victim. Any review should move away from process and KPI's that are often the focus of Umbrella bodies accreditation and focus on the support and work done with victims.
- The panel recommend that SafeLives develop a standard practice of advising professionals via their training programmes to inform victims what the outcome of the grading of the DASH risk assessments and encourage them to tell other professionals where they are able to. This will then increase empowerment and information sharing on risk factors, and inevitably foster increased context for each assessment undertaken, thereby reducing incorrect and siloed grading on each incident.
- Training and undergraduate level knowledge in Trauma Informed Responses should be adopted across police forces, and in Health and Social Care in England and Wales. This should be started from basic training/graduate programmes and continued throughout the course of a professional's career.
- A copy of this review to be sent with the Centre for Women's Justice Super Complaint findings[107], to DCC Maggie Blythe (National Police Chief Lead for Violence Against Women and Girls) and Alison Saunders (Director of Public

[107] https://static1.squarespace.com/static/5aa98420f2e6b1ba0c874e42/t/5c91f55c9b747a252efe260c/1553069406371/Super-complaint+report.FINAL.pdf

Prosecutions) to highlight the ongoing issues with powers designed to protect victims of domestic abuse, including restraining orders.

- The DA Commissioners office to commission a review of the risk assessment processes undertaken with victims and survivors of Domestic Abuse across multi-agency partners. The aim of the review would be to ensure risk assessments are effective, evidence based, and undertaken for the benefit of the victim's safeguarding.
- The DA Commissioner to commission research and present the data retained in the Home Office DHR Repository for victims of suicide, with a view to enabling local areas to understand the needs of victims better and reduce the harms caused by domestic abuse and the links to suicide in females.
- The Domestic Abuse Commissioner to promote Agenda Alliance research and recommendations into the links between Domestic Abuse and suicidal thoughts via the DA commissioner's newsletter and social media platforms[108]

[108] New Figures Reveal Link Between Suicidal Thoughts and Domestic Abuse - Agenda Alliance

Appendices

a. Action Plan

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

Somerset DHR 045 'Angela' Action Plan

Single Agency Action Plan

Organisation	Recommendation	Action	Lead Agency/ Professional	Target Date	Date of completion and Outcome
Avon & Somerset Constabulary	Panel recommendation – bespoke stalking awareness training	Liaise with other police force areas for advice on best workforce development and process changes to increase stalking awareness and CJS outcomes	Avon & Somerset Constabulary	September 2023	
Somerset NHS Foundation Trust	Practitioners to make note of previous alerts relating to domestic abuse and explore with patient	Spotlight on desktop for all staff/ discuss in safeguarding supervision/ discuss in level 3 safeguarding training and domestic abuse training.	Deputy Named Professional for Safeguarding Adults.	05/09/2022	Completed 07.03.2023 – discussed in safeguarding service whole team meeting.
	MIU Process for domestic abuse to be embedded within system and for all staff to be made aware	Questionnaire to be sent to MIU staff to test knowledge of local processes. To be discussed at safeguarding supervision and team away days.	Deputy Named Professional for Safeguarding Adults	05/09/2022	Completed 18.01.2023 – escalation process updated 24.11.2022 and shared with MIU's

Children's Social Care	Children's Services to continue to promote partnership working, the use of TAC/TAF meetings with the identification of a lead professionals when there are a number of professionals working with a family to ensure coordinated response	Partnership work at the Front Door is an essential area of practice which includes quality assurance work in collaboration with partners. This will continue to discuss partnership working, graduated response and use of TAC/TAF	CSC	Rolling 12 months, reviewed yearly in line with data review	Rolling 12 month QA framework in place
A&S Police/CSC partnership	Triage Lead- Police safeguarding role	The aim of the role in essence is to have one person within the police (LSU) who will be able to triage police reports accessing police and CSC systems to make informed and timely decisions whilst applying threshold application to ensure police reports are signposted and referred to the correct agencies and families receive the right support and the right time. This is a joint funded role for the next 12months between CSC and the police and has come on the back of significant work and pilots between the two	A&S Police with support from CSC	12-month Pilot	Commenced 9th May 2023

		agencies to try to improve working relationships and information sharing between agencies. Outcomes of the pilot to be shared with the CSP.			
Probation Service – Offender Management	Ensure appropriate level of SPO management oversight	Communication/ instruction to SPO	Probation Service Nationally	Already implemented as new national arrangements have been implemented for management oversight.	Now monitored by regular data sets, expected levels of monitoring and audit arrangements.
	Ensure the appropriate level of communication between OM, CYPS, PLW and ASC. Further guidance on accurate and timely reporting to be completed	Communication to all practitioners in Somerset by way of notice	PDU Head Somerset	Completed	Now monitored by regular report from Programmes showing documentation required, and an Escalation Report monthly

	Ensure OM's are confident in challenging the views of People on Probation (PoP).	Communication to all practitioners in Somerset	Senior Probation Officers – Probation Service Somerset	Implemented as part of supervision and training	Monitored by reflective practice with practitioners now set as routine.
	Risk management plans to be reviewed at appropriate times, significant event, e.g. when accredited programme has been completed	Ongoing Communication to all staff	Probation managers to remind staff and reference regularly by way of management oversight	Completed	Significant incident assessments required as part of practice, regularity of risk assessments monitored
Probation Service – BBR	Ensure the appropriate level of Treatment Manager oversight when perpetrator is subject to 1:1 delivery to ensure delivery meets objectives.	Communication / instruction to all Treatment Managers	Probation Programmes Teams	Completed	Reviewed on an ongoing basis Regular Treatment Manager discussions and QA with facilitators delivering 1:1 session. Tracked by

					Head of Programmes
	Ensure Facilitators are confident / competent in the application of skills/key concepts to people on probation's actual risk and needs	Facilitator development workshop	Probation Programme Teams	Completed	Reviewed on an On-going basis Regular Treatment Manager discussions and QA with facilitators delivering 1:1 session. Tracked by Head of Programmes
	PLW to ensure discussions regarding safety plans are recorded even where decision is that safety plan is not required	Communication / instruction to all PLW's (DASO's) Review of PLW induction / training.	Probation Programme Managers	PLW have updated the case record template to capture Professional Contacts, Restraining Orders and	Completed

				Safety Planning details.	
SIDAS	Panel recommend Livewest receive a copy of the published report to ensure learning is enabled within their organisation	Published report to be sent to Livewest CEO	Safer Somerset Partnership to Livewest Housing	Date of publication	
	Current SIDAS service provider to work with Commissioners to ensure appropriate advice and referrals are given to victims seeking non-molestation orders.	External national providers to be thoroughly vetted before recommending them to victims. Local solicitor firms are always preferable. Directory of options to be made available on SIDAS website supported by Safer Somerset Partnership	SIDAS provider and SSP	September 2023	

Somerset ICB	GPs to demonstrate in more professional curiosity when a patient who is suffering with low mood and is the soul carer of children with challenging needs or behaviours.	Consider a Carer's assessment if parents with children with extra needs disclose, they are finding life difficult. Promotion of Carer's assessment for Primary Care	Somerset ICB/SSP	September 2023	
Review Author and Chair	To adapt the model IMR template used by Somerset Safer Partnership	Share with DHR author at panel meeting two			Completed

Multi Agency Action Plan

Focus	Recommendation	Action	Lead Agency/ Professional	Target Date	Completed
Training/awareness raising	Using Angela's experience as a case study combine the key findings from this review and the other similar reviews in Somerset, and produce a webinar for discussion, learning and interaction in multi-agency training. Angela's sister to be involved in the webinar development, user involvement	Design webinar after publication of review. Disseminate to multi-agency forums for access over various dates	CSP	January 2024	

	developments, and feature in any training if she feels able.				
	Re-promotion of the commissioned SIDAS multi-agency training for the agencies incorporated within this review, to increase the awareness for professionals on the crime of stalking and Coercive and Controlling Behaviour, including a focus on tech-facilitated abuse.	SIDAS to re-promote training dates and target promotion at multi- agency partners	SIDAS	July 2023	
	Design and promote a leaflet including resources from Surviving Economic Abuse, to promote awareness of the issue of economic abuse, ensure information on access to specialist support on these issues, e.g., Via SIDAS and Citizens Advice Bureau (CAB). (This recommendation was provided by Angela's family).	CSP and SIDAS to action leaflet and awareness raising via social media platforms and websites	SIDAS/CSP	July 2023	
	CSP to promote children's status as victims in the DA Act, and continue promoting the services available via SIDAS for children	CSP to promote information about the status of children in the DA Act and SIDAS	CSP	On a rolling basis quarterly from September	

	and young people experiencing domestic abuse	services via the Somerset website.		2023 to August 2024	
	Training for SIDAS, to support parents of children with neurodivergence	SIDAS to source training for frontline staff	SIDAS	December 2023	
	ICB to incorporate learning from the emerging field of academic and practitioner understanding, on the impact of DA on menopausal women. Although focused on health professionals learning via leaflets/newsletters should also be extended to multi-agency partners to expand the knowledge for other professionals on this growing body of research.	ICB to source up to date information on menopause and domestic abuse and disseminate to health staff and CSP to extend to multi-agency partners as appropriate.	ICB/CSP	ICB - incorporated into 3x level 3 safeguarding training days that we are running throughout 2023. CSP to extend information sharing to Multi-Agency partners by December 2023	
	Specialist training for Avon and Somerset Constabulary on stalking and harassment to be commissioned.	Avon and Somerset police to commission specialist stalking training	Avon and Somerset Police	January 2024	

Review of systems and knowledge	The Safer Somerset Partnership to undertake a review of the pathway for victims and where systems and or required processes within agencies may hinder professionals from effective use of professional judgement, for example with the DASH.	CSP to initiate through next commissioning cycle	CSP	April 2023	Completed
	Avon and Somerset police to continue to monitor the use of DARA nationally and implement any learning within the force and feedback to the Somerset Community Safety Partnership.	Avon and Somerset police to liaise with College of Policing and other forces implementing the DARA model.	Avon and Somerset Police	Ongoing until roll out of DARA complete	
	SIDAS to adopt the use of Screening Assessment for Stalking and Harassment (SASH)[109] in all cases where stalking may be a feature of the risk to a victim.	SIDAS to implement use of SASH for victims of stalking	SIDAS	October 2023	
	Primary Care and Emergency Departments to review and promote the use of routine screening across all departments on a rolling basis, using the interaction between	Respective health departments to review information and promote the use of routine screening for staff using Angela's	Primary Care and NHS Trust	Ongoing until December 2024	

[109] https://www.stalkingriskprofile.com/stalking-risk-profile/sash

	the GP and Angela as a benchmark of good practice.	interactions with her GP as a case study			
	Agencies to report back to the Safer Somerset Partnership on the change implemented through training and or workforce development one year after the completion of the associated actions	Multi-agency partners to report back to CSP on outcomes of all above actions within one year of completion	Multi-Agency* partners who are part of this review	One year post action dates above	
	SIDAS and CSP to provide information (on websites and through social media platforms) for victims navigating the family court system including for those who have no access to legal aid e.g., via Rights of Women[110] and Shera[111] (this recommendation was provided by Angela's family).	SIDAS and CSP to action through websites and social media platforms	SIDAS and CSP	Ongoing quarterly from October 2023 for one year	
	The Education sector in Somerset to better support professionals within Education to be involved in Domestic Homicide Reviews, including via detailed IMR submissions and presence on panels.	Copy of the review to be presented to the CSP representatives from the Education sector	Education and CSP	Post publication	

[110] https://rightsofwomen.org.uk/further-help/

[111] https://www.shera-research.com/resource-category/family-court-resources

Suicide and Domestic Abuse	Multi-agency training for professionals to understand the link between DA and suicide – consideration of the use of Professor Jane Monkton-Smith's suicide timeline[112] as her research and work in this area progresses.	CSP to lead on initiating training for multi-agency partners on links between domestic abuse and suicide.	CSP	October 2023	
	In addition to multi-agency training, the Safer Somerset partnership to conduct analysis via a snapshot of data from all local DHRs into the resources needed to support women who are experiencing DVA where suicidal ideation may be a feature. The aim of this is to ensure appropriate interventions are commissioned in the future and the recommendations from the recent Agenda Alliance research is embedded where appropriate.	CSP to undertake a holistic review of all DHR suicide cases and provide a snapshot of the findings via the data provided. The report should then inform future actions that are needed to provide victims who are suicidal with the appropriate interventions. This can be done using the Agenda Alliance recommendations as a benchmark.	CSP	February 2024	

[112] https://eprints.glos.ac.uk/10579/16/10579_Monckton-Smith_%282022%29_Home_Office_Report.pdf

	Somerset Council and the ICB to undertake a mapping of a) availability of specialist counselling and b) what work is happening strategically. Then subsequently develop an action plan to progress next steps in ensuring there's availability or clarity of how people can access counselling services.	Somerset Council and ICB to review and provide clarity post mapping	Somerset Council and ICB	January 2024	
MARAC/ Information Sharing	Safer Somerset Partnership to seek assurance that the revised MARAC Process (commenced 01/10/2022) is effective and robust in providing risk management for high-risk victims of domestic abuse and that any rejection to hear a MARAC case is routinely recorded and shared with all multi-agency partners attending MARAC meetings.	CSP to action update from MARAC partners.	CSP	October 2023	
	Safer Somerset CSP to ensure multi-agency partners agree a lead professional in cases of domestic abuse, this can either be done via the MARAC process or through SIDAS/CSC where	CSP to liaise with MARAC partners/ SIDAS and CSC to ensure the process of lead professionals is clear and used appropriately.	CSP	October 2023	

	cases do not meet the MARAC threshold.				
Trauma Informed Practice	The Safer Somerset partnership to explore the expansion of trauma informed practice for multi-agency partners involved in this review, including in policies, training and in the requirements and benchmarks of commissioning.	CSP to initiate discussions and an action plan on trauma informed practice implementation across multi-agency policies and processes	CSP	March 2024	

*Multi-agency refers to all partners who were involved in the panel and any further stakeholders the CSP think are pertinent.

National Recommendations

Recommendation	Action	Lead Agency	Target Date	Completed
A reminder to local authorities of the use of a full combined chronology report which should be given to review chairs and authors.	Recommendation to be sent to Advocacy After Fatal Domestic Abuse to be published on the DHR commissioner's forum	CSP	Post Publication of Review	
The panel recommend a copy of this review is sent to Umbrella bodies that offer accreditations to DA services, for example, SafeLives and Women's Aid. Following this they should explore an option	Copy of the review to be sent to Women's Aid National Quality Assurance panel and	CSP/ Review Chair	Post Publication of Review	

to support services with Leading Lights accreditation or Women's Aid National Quality Standards when a DHR occurs, at no extra cost to the frontline provider. The aim would be to facilitate a review into the content of the work undertaken and support staff after the death of a victim. Any review should move away from process and KPI's that are often the focus of Umbrella bodies accreditation and focus on the support and work done with victims.	SafeLives Leading Lights panel.			
The panel recommend that SafeLives develop a standard practice of advising professionals via their training programmes to inform victims what the outcome of the grading of the DASH risk assessments and encourage them to tell other professionals where they are able to. This will then increase empowerment and information sharing on risk factors, and inevitably foster increased context for each assessment undertaken, thereby reducing incorrect and siloed grading on each incident.	Copy of the review and recommendation sent to SafeLives CEO	CSP/Review Chair	Post Publication of review	
Training and undergraduate level knowledge in Trauma Informed Responses should be adopted across police forces, and in Health and Social Care in England and Wales. This should be started from basic training/graduate programmes and continued throughout the course of a professional's career.	Copy of the report sent to College of Policing and Government Minister for Health and Social Care	CSP	Post publication of review	

A copy of this review to be sent with the Centre for Women's Justice Super Complaint findings[113], to DCC Maggie Blythe (National Police Chief Lead for Violence Against Women and Girls) and Alison Saunders (Director of Public Prosecutions) to highlight the ongoing issues with powers designed to protect victims of domestic abuse, including restraining orders.	Copy of the review to be sent to DCC Maggie Blythe and Alison Saunders	CSP	Post publication of review	
The DA Commissioners office to commission a review of the risk assessment processes undertaken with victims and survivors of Domestic Abuse across multi-agency partners. The aim of the review would be to ensure risk assessments are effective, evidence based and undertaken for the benefit of the victim's safeguarding.	Copy of the review to be sent to the DA Commissioner for England and Wales	CSP	Post publication of review	
The DA Commissioner to commission, research, and present the data retained in the Home Office DHR Repository for victims of suicide, with a view to enabling local areas to understand the needs of victims better and reduce the harms caused by domestic abuse and the links to suicide in females.	Copy of the review to be sent to the DA commissioner for England and Wales	CSP	Post publication of review	
The Domestic Abuse Commissioner to promote Agenda Alliance research and recommendations into the links between Domestic Abuse and	Copy of the review to be sent to the DA Commissioner for England and Wales	CSP	Post publication of review	

[113] https://static1.squarespace.com/static/5aa98420f2e6b1ba0c874e42/t/5c91f55c9b747a252efe260c/1553069406371/Super-complaint+report.FINAL.pdf

suicidal thoughts via the DA commissioner's newsletter and social media platforms[114]				

[114] New Figures Reveal Link Between Suicidal Thoughts and Domestic Abuse - Agenda Alliance

b. Home Office QA Panel Feedback Letter

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Suzanne Harris
Senior Commissioning Officer (Interpersonal Violence)
Somerset County Council
Maltravers House, Petters Way
Yeovil
BA20

21st December 2023

Dear Suzanne,

Thank you for submitting the Domestic Homicide Review (DHR) report (Angela) for Somerset Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 22nd November 2023. I apologise for the delay in responding to you.

The QA Panel agreed that the review was thorough, thoughtful and overall effectively captured key points. There was positive engagement with Angela's family and friends who participated in the review. The chair liaised with Angela's parents on including the children in the review process, although it was assessed that it would not be in their best interest at the time, it was positive that their views/voices were considered.

There was positive engagement with GP service, particularly when Angela made her first disclosure of DA, the GP evidenced professional curiosity regarding impact on Angela and children, undertook some basic safety planning with Angela, discussed DA services (SIDAS) and made a referral to Children Social Care (CSC).

There was good use of research within the report and the QA panel appreciated that the author drew connections between other DHRs, to demonstrate repeated learning.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- The QA panel highlighted the present tense used in the chronology as problematic, knowing Angela is deceased. They also highlighted that there are some typos and spelling errors throughout the report.

- The QA panel raised queries on points - 9.1 – *it would be helpful to explain what this is about as this is common practice*. And 9.8 – *Was he cautioned for an offence or charged and convicted or pleaded guilty later at court? What was the outcome in court in terms of the sentence?*

- The QA panel felt that the children's experiences of domestic abuse were unseen and unheard, which they found particularly concerning as the three children were neurodivergent, and therefore the impact may have been poorly understood.

- The QA panel agreed that it would have been helpful to have had a representative from education on the panel, especially considering the individual management review (IMR) issues identified in the review. This would have helped to provide an insight to any issues the children were experiencing around domestic abuse.

- The QA panel felt there was a lack of a trauma-informed care approach to Angela and a lack of joined up approached to the number of DASH's that were completed. There was also a swift discharge from DA services, despite her continuing to experience escalating issues of DA.

- The QA panel felt the report could have gone into further detail in relation to gaps in agency knowledge – there could have been greater emphasis on the tech-facilitated abuse Angela experienced, which was dismissed by officers. The need for greater understanding of the ways in which technology can be used in myriad subtle ways to control and abuse, long after separation, could have been highlighted more.

- The QA panel supported many of the national recommendations made, however noted concern on viability to implement all of them.

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