SAFER SOMERSET PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Charles died May 2022

Contents

Domestic Homicide Review

Somerset Community Safety Partnership

Charles died May 2022

Authored by Clare Walker
and
Katie Bielec

Completed October 2023

Published June 2024

Contents **Page Number**

Poem chosen by Debbie

l'm there inside your heart
I'm there
Right now l'm in a different place
And though we seem far apart
I'm closer than l ever was …..
I'm there inside your heart.

I'm with you when you grieve each day
And when the sun shines bright
I'm there to share the sunsets too….
I'm with you every night.

I'm with you when the times are good,
To share a laugh or two
And if a tear should start to fall ….
I'll still be there for you.

And when the day arrives
That we no longer are apart
I'll smile and hold you close to me ….
Forever in my heart.

Foreword

There is so much we could add about Charles although fundamentally his caring, compassionate nature shines through in this report. His inner strength is humbling, and we honour him for staying true to his beliefs no matter the adversity he faced. He was earnest in his concern for those in need. He took this to heart, acting in the best interests of those dear to him always attempting to improve their circumstances.

Charles was a kind and gentle man; he was committed to his partner Debbie and was a fundamental part of our family life. He had no children but loved Debbie's children and grandchildren as if they were his own. He enjoyed going on holiday with America being his favourite destination. He loved being at home, having tropical fish, completing DIY and having a quiet life in the heart of Somerset. He was described as someone who would help anyone when they needed it.

He worked at the same company for nearly 30 years and was a valued and highly skilled member of the small team. His friends at work knew him as 'Wack' which later came out as being due to him smoking 'roll ups'! He was well liked and respected by his peers and friends.

Justice for his sacrifice is impossible to quantify. Nevertheless, he most certainly deserves recognition for his efforts to provide continuous support and a safe refuge whenever he could. It is heartbreaking to think that, ultimately, had the professionals properly addressed the underlying issues, Charles and his immediate family could have lived with stability and security. Had these then been considered the norm - rather than the chaotic existence that did persist - Charles would, in all probability, still be with us. This leaves a sense of betrayal throughout the family.

As laughter was an important part of our lives with Charles we would like to conclude on a lighter note. Fortunately, we all shared a similar sense of humour. This is just as well as we would often find amusement within serious situations! Hilarity always punctuated our family gatherings - happy or sad

- wherever they may have been, helping us to deal with those dark, difficult moments. Unsurprisingly, we often still chuckle together although it now comes with added poignancy. That notwithstanding, we often sense Charles laughing with us or, perhaps more frequently these days, at us!!

So we will seize the opportunity for revenge by divulging Charles' disgust at receiving a most unusual gift in the form of a giant gnome! The rest of us chortled as he beheld, with a look of horror, this apparition before him! Although he dutifully took said gnome home, he was already making plans to be rid of it! The gnome's demise came some months later - being 'accidentally' run over whilst in the process of being moved to an alternative location. In certain quarters, its existence has never been forgotten and doubtless, this poor, innocent gnome will provide the family with a jolly good laugh for many a year!

Charles loved music and going to gigs - seeing Green Day was always top of his list. With a little artistic license, using some of the tracks from albums in Charles' record collection, we have created a rather cryptic, family tribute:

Charles was a true 'travellin man', a bit of a 'speed king' particularly when on 'holiday' in 'America'. He was no 'American idiot' though, more a 'free bird' - hardly an 'Albatross' definitely not a 'songbird'!!

When Charles wasn't saying 'I'm in love with my car' he was telling Debbie 'you're my best friend', the 'love of my life' - we share 'a kind of magic' and 'I'm always touched by your presence dear'. 'Come with me', 'there's a place for us', he'd say, let's climb that 'stairway to heaven' …..

Charles, you were always 'good company' and we desperately still 'wish you were here'. 'Heroes are hard to finding' but you are ours - not least because you would say 'have a drink on me'.!! We all owe you a huge 'Thank you'. We 'don't stop believing' that you will soon be 'homeward bound' to be with us again. In our 'dreams' on a 'black night', looking up at the stars, we know you are enjoying 'the great gig in the sky' and will continue to 'shine on you crazy diamond'.

There is an unspoken but innate understanding between siblings, now extending to Debbie, in which, despite not living in each other's pockets, we know that in times of need the others will do whatever they can to help. It is a belief without expectation. Just an inherent special bond that unites us. This allows us to live safe in the knowledge that everyone will do their best at any given time - which on occasion, may indeed be nothing; that is ok too.

Thus, how desperately it hurts that we could not be there when Charles needed us most. Nevertheless, how blessed are we all to have had Charles in our lives - his memory sustains us. As does the ongoing support we continue to give each other, sharing the load when, as often happens, it threatens to weigh us down.

Emotions are still raw, and it is hard to comprehend that Charles cannot return to us. However, if we can spare other families from suffering such a traumatic, heartrending experience that may bring some small comfort to the family as we go forward. Such a caring, modest, unassuming and (referencing Lynyrd Skynyrd) 'simple man' should be remembered for all his good deeds - carried out quietly, without fuss; Charles loathed being centre of attention, yet his manner was inspirational - many could learn much from him.

Preface

Safer Somerset Partnership, panel members and the authors wish at the outset to express their deepest sympathy to Charles's family. This review has been undertaken in order that lessons can be

learnt; we appreciate the engagement from his family and friends throughout this difficult process. The chairs of the review aimed to work with those who knew him sensitively and with compassion.

This review has been undertaken in an open and constructive manner with all the agencies and all engaged positively. This has ensured that consideration of the circumstances has been carried out in a meaningful way and address with candour the issues that it has raised. The review and every panel meeting have been conducted with an open mind and aims to avoid any hindsight bias.

1. Introduction

1.1 Charles was killed by Peter (Charles's stepdaughter's ex-partner) and Craig (Peter's friend who had no family links and therefore is not included within the review) in May 2022, also involved and at the scene was Becky (Charles's stepdaughter). Due to Charles and Becky being family members Safer Somerset Partnership (SSP) identified the case met the criteria for a Domestic Homicide Review (DHR).

1.2 This DHR is a statutory requirement and it examined agency contact and/or involvement with Charles, Peter, and Becky, their responses, interventions and support provided. All of those involved were residents in Somerset prior to Charles' death. The report will highlight positive and supportive practice along with missed opportunities and/or any barriers in accessing services and any learning that can be shared to reduce the risk of such a tragedy in the future.

2. Glossary

2.1 **BRAG** - A tool to risk assess and record all forms of vulnerability or safeguarding concerns.

2.2 **DASH RIC**[1] – The national Domestic Abuse, Stalking and Harassment Risk Indicator Checklist to help identify those who are at high risk of harm and manage their risk.

2.3 **DHR** – Domestic Homicide Review

2.4 **FSG**[2] – Family Safeguarding Team – A combined team within children social care, independent domestic abuse, substance misuse and mental health workers to support families.

2.5 **GP** – General Practitioner a medical doctor who treats acute and chronic illnesses and provides preventive care and health education to patients.

2.6 **IDVA** – Independent Domestic Violence Advocate, support for high-risk victims of domestic abuse.

2.7 **IMR** – Individual Management Reports are required by agencies who were involved providing information of contact and action, analysis and possible learning and recommendations.

2.8 **LSU** - Lighthouse Safeguarding Unit a joint team supporting victims and witnesses of crime within Avon and Somerset Police.

[1] https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf
[2] https://www.somerset.gov.uk/children-families-and-education/family-solutions-somerset/

2.9 **MARAC** – Multi Agency Risk Assessment conference, meeting to discuss high risk domestic abuse cases with the aim to increase safety, reduce risk and interrupt the abusive behaviour of the perpetrator.

2.10 **MASH** – Multi-Agency Safeguarding Hub

2.11 **OIC** – Officer in Charge, an investigator, and a disclosure officer to perform different functions.

2.12 **PNC** – Police National Computer

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

2.14 **SIDAS** – Somerset Independent Domestic Abuse Service

2.15 **SSP** – Safer Somerset Partnership

3. Timescales

3.1 In 11/08/2022 Safer Somerset Partnership received a Domestic Homicide Review referral regarding the killing of Charles from Victim Support. The decision to carry out the review was made in 02/10/2022. In November 2022 independent chairs were commissioned with the aim of completing the review within the six months statutory timeframe.

3.2 The Home Office Multi-Agency Statutory Guidance for Domestic Homicide Reviews[3], (paragraph 46) states that the target timescale for completion of the review of six months. Initial information was sought by Safer Somerset to ensure different agencies were aware of the DHR and the requirements as well as the introductory panel meeting. However, the review was unable to be completed in six months due to the on-going criminal case which concluded in February 2023 as well as additional information required by the panel. This caused a delay in any contact with Charles' family, Becky, and Peter. This delay was approved by Safer Somerset Partnership and the panel meetings were held in December 2022, February 2023, June 2023, and September 2023.

4. Confidentiality

4.1 In line with the Statutory Guidance (paragraph 75), to protect the identity of the victim, perpetrator, relevant family members and others and to comply with the Data Protection Act 1998 pseudonyms have been used which were chosen by Charles' family.

4.2 The sharing of information between agencies in relation to this review was underpinned by the Information Sharing Protocol which is in place to facilitate the exchange of personal information to comply with the requirements of Section 9 of the Domestic Violence, Crime and Victims Act 2004[4] to establish and coordinate a DHR.

4.3 Panel meetings were all confidential and any sharing of information to third parties was carried out with the agreement of the responsible agency's representative, the panel and chair. The findings are restricted to authors of the reports, their managers and panel members. Once agreed by the SSP Board, the review will be presented to the Home Office for

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

[4] https://www.legislation.gov.uk/ukpga/2004/28/contents

final approval. Any initial learning identified through the review process will be acted on immediately.

4.4 Charles was 56 years old and was white British. Peter was 35 years old, and Becky 32 years old, both are white British.

5. Terms of reference

5.1 The review will:

- Consider the period from 01/05/2020 to Charle's death, subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events that are relevant, and which should be included.
- 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 criminal justice proceedings in terms of timing and contact with the family.
- Aim to produce a report within six 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 whether familial abuse) 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 Charles or his family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
    - Against the Equality Act 2010[5] protected characteristics.
    - Regarding children and pregnancy and any potential impact this had ensuring the safeguarding of any children during the review.
    - Whole family approach
- 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 and amongst 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.

[5] https://www.legislation.gov.uk/ukpga/2010/15/contents

- 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. This is to include consideration of the impact of COVID-19. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

6. Methodology

6.1 Domestic Homicide Reviews became statutory on 13/04/2011 under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:
a) A person to whom 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; held with a view to identifying the lessons to be learnt from the death.

6.2 Agencies were identified to provide IMRs after SSP completed a scoping exercise with statutory and non-statutory agencies across Somerset. Each agency was provided with the terms of reference and asked to review their involvement with Charles, Peter and/or Becky including interviewing any staff where appropriate. All were asked to highlight positive practice, any learning, recommendations, and actions.

6.3 All IMRs were quality assured and any recommendations and learning agreed by senior members of staff within each organisation.

6.4 In addition to the IMRs provided by agencies the chair was also provided with invaluable family and friends insight into Charles' background and his relationship with Peter and Becky.

6.5 Various pieces of research have been used within the analysis and are referenced throughout the report.

7. Involvement of family and friends

7.1 A letter was sent to Debbie regarding the DHR who was being supported by a Victim Support – Homicide Support Worker. The chairs met with Debbie and the advocate at her home address and continued to remain in contact throughout the process.

7.2 Charles's siblings were supported by Victim Support and were also involved in the review.

7.3 A letter explaining the DHR was given to Becky by social services providing her with the opportunity to speak with the chairs, unfortunately this did not occur. Due to the significant

amount of information with the report involving Becky social services sought permission from Becky and encourage her to engage with the review. Although the chairs have not spoken with her the panel have been reassured, she is aware fully of the review and the process involved.

7.4 Charles' employer was able to provide an insight into who he was as a colleague and friend. Emails were also sent to Charles' next-door neighbours offering to speak with the chairs.

7.5 The chairs met with Peter in prison with his probation officer in in April 2023.

8. Contributors to the review

8.1 IMRs were all authored by independent staff within each organisation who were not directly involved with any person discussed within the review. Those who provided and presented an IMR to the panel were:

Agency	Representative	Information provided on
The You Trust (current SIDAS provider)	James Dore	Becky and Peter
Children Social Care	Sussanah Heywood	Charles, Debbie, Becky, Peter
NHS Somerset ICB (on behalf of Primary Care)	Emma Read	Charles
Avon and Somerset Police (IMR author)	Nigel Colston	Charles, Debbie, Becky, Peter
Somerset Drug and Alcohol Service	Jane Harvey-Hill	Becky and eldest child

8.2 The panel comprised of agencies recommended within the statutory guidance as well as agencies with specialist knowledge of male victims and domestic abuse. All panel members were independent of any involvement of those subject to the review. Each panel member was required to review each IMR, provide feedback at panel meetings and support the process. The review panel consisted of:

Agency	Representative and role
Bielec Consultancy Ltd	Katie Bielec – Chair and Author
Clare Walker Consulting Ltd	Clare Walker - Chair and Author
SCC Public Health (SSP)	Suzanne Harris - Senior Commissioning Officer
The You Trust (current SIDAS provider)	James Dore - Strategic Manager
Children Social Care	Cathy Jones - Head of Service Children Looked After & Leaving Care (Acting)
NHS Somerset ICB (on behalf of Primary Care)	Emma Read – Safeguarding Lead
Avon and Somerset Police	Sam Williams – Detective Chief Inspector
Somerset Drug and Alcohol Service	Jane Harvey-Hill - Safeguarding Manager

9. Authors of the Overview Report

9.1 Katie and Clare are both independent domestic abuse consultants, completing the Home Office Domestic Homicide Review Training and accredited DHR chair training with AAFDA[6]. They are also both members of the AAFDA DHR Network

[6] https://aafda.org.uk/

9.2 Katie has also completed training and a reviewer with SILP[7], is a member with Standing Together Against Domestic Abuse Coordinated Community Response and The Employers Initiative on Domestic Abuse. She chairs MARAC, chaired Multi Agency Risk Management Meetings and stalking clinics. She is an associate trainer for Safelives, Surviving Economic Abuse, Rockpool, The Hampton Trust, a guest lecturer for Bournemouth University and is an accredited trainer delivering Coercive Controlling Behaviour and Stalking Awareness.

9.3 Katie was previously a Metropolitan Police officer for 5 years working in a variety of roles, is a qualified IDVA, IDVA manager, Independent Sexual Violence Advocate (ISVA) Manager and managed domestic abuse services between 2010 and 2021 with The You Trust. Although the You Trust are panel members, were the provider of the domestic abuse service within Somerset (SIDAS) at the time of Charle's death and was involved with Becky, Katie was the manager in Dorset and was not connected with this project during this time. Since leaving The You Trust there has been no connection with the service or Katie's consultancy.

9.4 Clare Walker is an independent Domestic Abuse Consultant providing training on domestic abuse, coercive control, parental alienation, and 'Who's In Charge?' programme.

9.5 Clare is a Domestic Abuse Expert Witness, for victims of domestic abuse going through civil or criminal court, including in the High Courts, UK and overseas. Clare is Visiting Lecturer at various universities, with annual visit for DeMontfort & Derby Universities. Clare is a founding member and co-creator of the VOICE Programme (Victims of Intimate Coercive Experiences).

9.6 Clare has previously managed local services regarding good practice and policy development, domestic abuse, post-sexual abuse, learning disabilities, mental ill health, and parenting.

9.7 Katie and Clare are not associated to any agency who have provided information for the review or had any personal or professional involvement with those involved or their families.

10. Parallel Reviews

10.1 In November 2022 Peter and Craig pleaded guilty to manslaughter and sentenced to 7 years imprisonment. In February 2023 Becky was found guilty of battery with a suspended sentence and a 5-year restraining order protecting Debbie.

10.2 The Coroner has permanently suspended the inquest into the death of Charles based on the criminal conviction of a third party for a homicide offence in relation to his death[8]. As such, there was no inquest and no outcome to report.

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

11. Equality and Diversity

11.1 The chair and panel members considered whether any protected characteristics[6] were relevant to the review. At the time of Charles' death, Charles was 56 years old, Peter was 35 years old, and Becky was 32 years old. All were identified to be white British. There was no information to suggest Charles or Peter had a disability.

[7] https://www.reviewconsulting.co.uk/silp-reviews/

[8] Schedule 1 of the Coroners and Justice Act 1996

11.2 Becky told services that she had Multiple Sclerosis (MS) or ME[9], the review has been unable to confirm this, whether it was recorded as a disability or if she required any additional support, even so it has been taken into consideration whether this impacted the services she received.

11.3 Charles sex was taken into consideration for this DHR as a risk factor due to domestic abuse and domestic homicides of men being significantly fewer than female victims. The latest Office for National Statistics figures (2022/23) show that one in three victims of domestic abuse are male equating to 751,000 men (3.2%) and 1.38 million women (5.7%). From this, 483,000 men and 964,000 women are victims of partner abuse. (ONS 2022/23). The panel felt it important to understand if Charles faced barriers in identifying the abuse and seeking support as well as agency responses to him and others involved in the review.

11.4 Mankind[10] states that ONS 2023 data shows men are more likely to be subjected to domestic abuse between 20 – 24 years old with the number of victims reducing significantly after 40 years old. This is not to say it does not happen and it is essential when exploring familial abuse age is explored to understand the risks those who are older face from family members.

11.5 No religious beliefs were disclosed for anyone involved within the review.

12. Dissemination

12.1 Charles' family and all agencies involved in the review are aware the Overview Report and Executive Summary will be published once agreed by the Home Office; however, the action plan has already been disseminated with all relevant agencies to ensure immediate action and learning can be taken forward. All other reports and IMRs will remain confidential and will not be shared.

12.2 The final Overview Report and an Executive Summary will be published on the SSP website[11] and shared with the family, Safer Somerset Partnership Board, Avon and Somerset Police Crime Commissioner and the Domestic Abuse Commissioner once agreed by the Home Office.

12.3 SSP and the chairs will work with the family and other partners with regards to any public/press interest, the reports will be available on the Somerset Council website.

13. Homicide the facts

13.1 On the night of Charles' death Becky found messages on her eldest child's (aged 12 at the time) phone from Charles. She became concerned about the content of these messages, one of which called the child "*hot stuff*". This resulted in Becky sending the messages to Peter, her ex-partner.

13.2 Peter and Craig drove from where they lived, approximately 1 hour drive away and attended Becky's address after receiving the messages, both had been drinking prior to their arrival. Peter called Charles on the home landline on 3 occasions. At first Charles was in the shower and unable to speak to Peter, on the final call, Charles told Peter he would need to get dressed to come to the flat.

[9] https://www.nhs.uk/conditions/chronic-fatigue-syndrome-cfs/

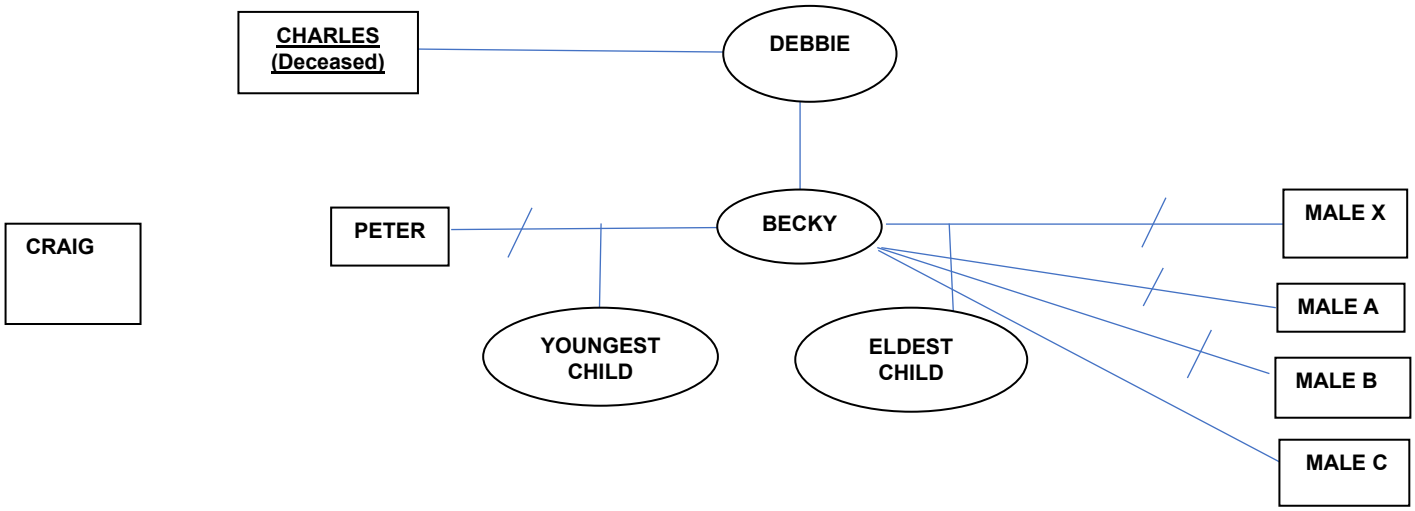
[10] https://mankind.org.uk/statistics/statistics-on-male-victims-of-domestic-abuse/

[11] https://somersetdomesticabuse.org.uk/domestic-homicide-reviews/

13.3 Peter, Becky, and Craig then attended Charles and Debbie's home address (this was in the same town as Becky), whilst Charles was getting dressed. Debbie answered the door to Peter who told her he wanted to speak to Charles. When Charles came to the door Peter and Craig repeatedly punched him. As a result of the attack Charles quickly fell to the floor unconscious; he was taken to hospital where he subsequently died from his injuries.

13.4 Police carried out further investigations with regards to the messages sent by Charles, and no improper or criminal activity was found.

14. Genogram



	Relationship
Charles	Long term partner with Debbie, Stepfather to Becky, Step-grandfather to Becky's children
Debbie	Charles long term partner, Becky's mother, and Grandmother to Becky's children
Becky	Debbie's daughter, Charles's stepdaughter, Peter's ex-girlfriend, mother to 2 children
Peter	Becky's ex-partner, father to Becky's youngest child
Eldest Child	Child of Becky and Male X
Youngest Child	Child of Becky and Peter
Male X	Father to Becky's eldest child (he is not involved within this review)
Male A	Becky's ex-partner (during 2020)
Male B	Becky's ex-partner (during 2021 – 22)
Male C	Becky's partner at the time of the Charles' death (during 2022)
Craig	Peters' friend and was found guilty of the manslaughter of Charles

15. Family and relationship background

15.1 Charles was born in Dorset and moved to Somerset when he was 2 years old. His parents were landlords of several public houses, he went to a local school and never ventured far, settling down with Debbie in the same town he grew up in.

15.2 Charles has 2 siblings and 3 step siblings all of whom were close even though they all live across the country.

15.3 Charles and Debbie were partners for 17 years; they were never legally married however they lived together for many years.

15.4 Debbie has 2 sons; both are adults and did not live with the couple. Debbie's relationship with her daughter was fractured, even so Debbie and Charles provided support to Becky's two-children.

15.5 Becky's youngest child is with Peter however, Peter considered Becky's eldest child as his own. Becky and Peter had been in an on/off relationship for 9 years. At the time of Charles' death, Peter was living with a new partner and Becky was in a new relationship, neither of the new partners were linked with Charles' death in any way.

16. Chronology

16.1 The panel and authors identified this review as complex due to the dynamics of the relationships, therefore as much information on all those involved was gathered. The panel have made all attempts to ensure the review was proportionate however, it is noted there is extensive information and analysis on Becky due to there being very little information on Charles or Peter.

16.2 The following information has been provided by agencies which was outside the scoping dates but relevant to the report due to the consistent prevalence of domestic abuse:

16.2.1 Since 2010 Becky has been known to services due to domestic abuse, substance misuse and mental health.

16.2.2 When Becky was pregnant with her eldest child in 2010, the unborn child was made subject to a child protection plan due to the risk of significant physical and emotional harm from domestic abuse (not Peter). In 2011 due to the continued risk of domestic abuse, Becky and her child moved to a refuge approximately 1 hour away from her family for 18 months. Care proceeding concluded at the end of 2011 with Becky being given a Residency Order, children social care involvement ceased in April 2012.

16.2.3 According to children social care records Becky and her eldest child then moved to Birmingham and North Somerset however, no further information was available.

16.2.4 Avon and Somerset Police were involved with Peter and Becky on fourteen separate occasions between May 2012 and September 2016 (the children were known or assumed to have been present at most of these events).

16.2.5 All fourteen events were logged as a 'domestic incident', 'domestic assault', 'domestic argument', and on one occasion, 'domestic burglary' and all described verbal arguments. Five were significant assaults, three of which were within less than three weeks of each other (all occurring between 1/12/2012 – 13/12/2012). Six detailed both Becky and Peter being intoxicated at varying degrees. Of the fourteen events Peter was arrested on three occasions, with one failed attempt to arrest (Peter was unable to be located). With each interaction with the Police there was no reference to the mental health status of either person.

16.2.6 In 2014 Peter was convicted at North Somerset Magistrates Court and sentenced for assaults against Becky. He received a Community Order with a requirement to complete Building Better Relationships[12], Supervision for 2 years and unpaid work supervised by the National Probation Office.

[12] https://www.gov.uk/government/publications/evaluating-the-building-better-relationships-programme-feasibility-study-for-an-impact-evaluation-of-proven-reoffending

16.2.7 Becky gave birth to her youngest child in June 2016. In September 2016, Somerset children social care received a request of information from North Somerset regarding a domestic incident between the couple. Information stated both parents were under the influence of alcohol, they remained in the relationship and both children had been removed to Becky's biological father and partner for the weekend as a place of safety.

16.2.8 North Somerset children social care issued proceedings in early 2017 with an outcome of a Supervision Order ending in June 2017.

16.3 Information within the terms of reference scoping dates (May 2020 – May 2022):

16.3.1 In mid-May 2020, an urgent strategy meeting was held with regards to the children returning to the care of Becky, who had resumed her relationship with Peter. All partners agreed the Section 47 of the Children's Act 1989[13] threshold had not been met and no assessment was completed.

16.3.2 During late July 2020 Becky called Police stating that Peter had "dragged her out of his address" and had "been physical" with her, she had visible bruising to her right arm and around her throat, Peter was arrested, the children were not present at the time of the incident (this occurred in North Somerset). A DASH RIC was completed which was graded as high risk, a 12-month STORM[14] maker added to Becky's phone, she was taken to temporarily stay with her father, a referral was made to NextLink (IDVA Service), MARAC, Children Social Care and Education. She was also provided with advice regarding the HollieGuard App and contacting her GP.

16.3.3 Peter was subsequently released on pre-charge conditional bail, with conditions not to contact Becky nor to attend any location where she might reasonably be.

16.3.4 NextLink received a referral from the Police a few days after the incident. After 2 attempts to make contact, they spoke with Becky; she was unable to complete the assessment and agreed to a call the following day. A call was made and there was no reply, 2 further calls were attempted with no success and the case was closed. Due to Becky not engaging with the service, NextLink referred her to MARAC.

16.3.5 In mid-August 2020 Becky was heard at North Somerset MARAC with Peter as the named perpetrator. Present at the meeting were Police, Next Link, Children Services, Children Centre, Education, Adult Social Care, Hospital, Mental Health, Health Visitor (Sirona Care and Health), NPS and CRC (Probation), 'We are With You' (Drug and Alcohol Services) and Housing. Information shared at the MARAC:

- **Police** – *Police were met by Becky who was in the stairwell of Peter's flat, she was in shorts and a t-shirt and had visible bruising on her arm and throat. She stated Peter had caused the injuries by grabbing and dragging her from the lounge/bedroom and into the hallway. He had called his younger brother from the flat above who had assisted in evicting Becky from the flat. Becky stated they had consumed a 75cl bottle of vodka together, she was emotional stating she and Peter had separated 3 to 4 weeks previously but were still sleeping in the same bed. Due to her intoxication a statement was not taken.*
- **NextLink** – U*nable to contact and closed.*
- Children Services – *Open for assessment, the family were with a friend and* Becky *was not planning to return to the relationship.*

[13] https://www.legislation.gov.uk/ukpga/1989/41/section/47
[14] Treat as urgent marker

- **Adult Social Care** - *September 2016* Becky *had been headbutted by Peter but stated he had left the property and she was aware of support services. Agreed to close, she was asked if she required support regarding her MS, but she declined.*
- **Health Visitor** – *The children had moved school and nursery;* Becky *had told her health visitor she suffered depression and ME.*
- **NPS (Probation)** – *Peter was previously known for Actual Bodily Harm (ABH) against* Becky *in 2014, requirements to complete BBR – nothing current.*
- No information was shared or held by other services.

16.3.6 Actions from the MARAC:

- MARAC to MARAC transfer to Somerset.
- The social worker to encourage and support Becky to engage with domestic abuse support services in Taunton, Somerset.

16.3.7 The day after the MARAC Becky told Police that she wished to withdraw her statement, the Police continued to investigate.

16.3.8 In August 2020 Becky reported to children social care that Peter had hit her and thrown a drink over her (this was not reported to the Police), as a result she had ended the relationship. Becky was caring for the children, and they were all living in North Somerset at the time.

16.3.9 At the beginning of September 2020, the social worker referred Becky to SIDAS indicating she and her 2 children were living with Debbie and Charles. Within the referral it highlighted physical and emotional abuse, that the couple had separated, and that Becky was clear she did not want to resume the relationship. They raised concerns that both had stated they loved each other and, given their history of reconciliation there was a risk this could happen again. They also highlighted that Becky was vulnerable to further abusive relationships.

16.3.10 The DASH within the referral to SIDAS scored 7, however SIDAS escalated the referral to an IDVA due to the non-fatal strangulation incident in July 2020. Even though allocated to an IDVA it was not referred to MARAC and no MARAC-to-MARAC transfer had been completed by North Somerset.

16.3.11 Two days after receiving the referral, attempts were made to contact Becky via phone and text by the Single Point of Contact (SPOC) team. Contact was made four days after the referral, Becky agreed to support, and an initial risk assessment was completed along with safety advice. During this she confirmed she was living with her mother and stepfather and disclosed Peter had previous broken her nose whilst pregnant. She was assigned an IDVA, and an initial telephone appointment was scheduled for a couple of days later.

16.3.12 On the planned date Becky and the IDVA spoke on the phone with the IDVA outlining the support they could offer. Further safety advice was provided along with a discussion regarding a non-molestation order.

16.3.13 The day after this conversation Becky met with the IDVA face to face, a DASH was completed where she scored 13 (medium risk). Becky disclosed Peter had been sending her messages daily and he was currently being nice. She was advised to call 101 and speak with the OIC with regards to the breach of bail, however, Becky stated Peter had told her the messages had been removed. The IDVA made attempts to confirm this, but the OIC was not on duty and a message was left. The IDVA discussed refuge, but this was declined, target hardening was offered for Debbie's property, but this was refused.

16.3.14 During the meeting Becky informed the IDVA she had an appointment with her GP the following week to discuss her mental health, depression, and her diagnosis of relapsing MS. She was also in the process of applying for housing and a homelessness application had been submitted to Southwest and Taunton Housing options. She also updated the IDVA that her social worker was completing a Children and Families Assessment and was seeking to transfer the case to Somerset Children Social Care.

16.3.15 Becky disclosed to the IDVA she was in a new relationship (no details of the new partner were collected), it was in its early stages and going well, Peter was aware of this, and apparently happy about it. After the meeting concluded no further appointments were booked with Becky.

16.3.16 A week later, the IDVA was contacted by the OIC who confirmed the investigation into Peter was ongoing however, there were no bail conditions. It was agreed the IDVA would be kept up to date with any charging decisions.

16.3.17 Becky contacted the IDVA and informed her that Charles had told her she was unable to live there any longer and had given her one week's notice. Becky believed this was to assist in her housing application rather than issues within the household, refuge was discussed but declined.

16.3.18 The IDVA notified Becky she was going on annual leave from the end of September for 2 weeks and gave the SIDAS helpline number and explained she could call if she required support during this time. No future appointments were made with the IDVA. The IDVA updated the social worker of Becky's housing situation, she also made attempts to contact Becky's housing officer sending them an email regarding Charles' decision to ask Becky to leave.

16.3.19 In mid-October (3 weeks after the last call between the IDVA and Becky) the IDVA sent a text asking how Becky was, who confirmed she remained at Debbie and Charles property and continued to bid on Home Finder. The following day the IDVA sent a further text asking to arrange a date for a face-to-face appointment, there was no reply to this request.

16.3.20 Due to the IDVA being ill, Becky was not contacted until the end of October (this had not been relayed to Becky). Upon the IDVAs return she called Becky and sent a text offering an appointment at the end of October 2020. Becky replied she was unable to meet in October due to Charles and Debbie being on holiday and having no childcare but suggesting an alternative of mid-November 2020. An appointment was booked, and an alternative venue was offered but declined.

16.3.21 The nation went into a second COVID lockdown on 31/10/2020 ending 14/11/2020.

16.3.22 On the scheduled appointment date in November the IDVA called Becky, a new DASH was completed with a score of 8 (medium risk) and her support plan was updated. During the call Becky confirmed there had been no further abuse from Peter and contact had been going well. She told the IDVA that she had withdrawn her statement and believed Peter had been arrested 2 weeks prior but did not know why (there has been no confirmation of this). Later that month the Police submitted their investigation to the CPS for advice with regards to initiating an evidence-led prosecution. Becky had accepted a property in the same town as Charles and Debbie, target hardening was offered but declined and safety advice was given. Becky updated the IDVA that children social care had closed her case and there were no further appointments made.

16.3.23 The IDVA followed up this conversation with the social worker in North Somerset who confirmed they were closing the case and would not be transferring to Somerset due to no ongoing identified concerns. They also contacted the OIC for an update on the investigation, who confirmed they were awaiting a charging decision but there was a backlog due to COVID and this was expected in December 2020.

16.3.24 The following week the IDVA and Becky discussed the Police investigation, she was advised to consider a restraining order, and how this would work. Becky was unsure of whether she wanted this and asked to think about it. Becky was due to move into her new property and was receiving support from the Citizen Advice Bureau and other charities to assist with furniture and white goods.

16.3.25 At the end of November 2020, the IDVA made attempts to contact Becky via phone and texts. Becky apologised for missing the calls having been busy moving the previous week, an appointment was scheduled for the beginning of December 2020. The IDVA contacted the LSU requesting an information marker be placed on the new property.

16.3.26 The day before the scheduled appointment Becky cancelled due to her and the children being unwell and awaiting results from their COVID tests. It was agreed a new appointment would be made once the results had returned. The IDVA called Becky two weeks later informing her she was on annual leave over the Christmas period and provided Becky with the SIDAS number.

16.3.27 At the beginning of January, the IDVA sent a text and 'WhatsApp' message asking for Becky to contact them. Seven days later the IDVA made contact and a phone support session was booked at the end of January. During the support session Becky stated she no longer required support and agreed for her case to be closed, an exit DASH of 9 was completed. During this month, the CPS determined that there was insufficient evidence to proceed due to the victim (Becky) withdrawing support.

16.3.28 In February 2021 police were called to a potential breach of COVID regulations where Becky was found with another female, the children were also present. Becky became very distressed stating she wanted to kill herself and was obstructive towards the Police. The children were collected by Debbie and taken to Debbie's home. It was reported the children were both visibly upset, a referral was made to MASH, health, and education. A detailed BRAG was completed to identify risk and vulnerability which was rated Green (low risk).

16.3.29 Police were called by Debbie in late May 2021 with concerns for her daughter as she had turned up during the evening *"off her face"* insisting she needed to take the children to school. She stated an argument ensued, Becky was alleged to have tried to steal tobacco and a mobile phone and then pushed Debbie causing a scratch to Debbie's hand. Charles was present and took Becky back to her home whilst the children remained with them. Becky was later found at her flat by a friend who encouraged her to attend hospital due to drug consumption, where she was discharged the same evening. Safeguarding referrals were made to the GP, children social care, and education. No criminal complaints were made, and no Police action was taken.

16.3.30 Children social care received a referral from the hospital after Becky had presented stating she had taken an overdose in front of the children the previous night. She also disclosed she had punched her mother and headbutted her stepfather, it is unclear if the children witnessed the assault (no allegations of this nature were made by Charles or Debbie). The children

remained with the maternal grandparents. Becky was discharged from hospital and was assessed by the mental health team with actions for the Home Treatment team to follow up with calls, there was also a referral to the psychiatric liaison team (the review has been unable to determine any action taken regarding Becky's mental or physical health).

16.3.31 Shortly after this incident the Police referred the family to children social care to raise concerns that Becky was in a relationship with a known drug user (cannabis and cocaine). He suffered poor mental health, had previously self-harmed and was known to carry weapons. Becky was attending his address on most days which they believed was to use drugs and alcohol. Concerns were raised that Becky was obtaining illicit substances from Peter and that she was vulnerable to abusive relationships.

16.3.32 As a result of these recent referrals a Children and Families Assessment was completed with the decision to support the family under a Child in Need (CiN) Plan due to the ongoing concerns around parental mental health and substance misuse (there was no mention of the risk of domestic abuse).

16.3.33 At the end of June 2021 Becky reported harassment by an ex-partner (not Peter), Police recorded no criminal offences disclosed, no further action was taken, and no DASH was completed. Safeguarding referrals were made to children social care, education, and health.

16.3.34 At the beginning of September 2021 Becky was allocated substance misuse (SDAS) and mental health workers who were part of the Family Safeguarding Team. Domestic abuse had not been identified as a risk or need for support, so no domestic abuse worker was allocated.

16.3.35 Within a week of allocation, the substance misuse worker arranged to meet Becky. At the assessment Becky stated she was not keen on stopping her use of cannabis or alcohol but would consider reducing and gaining control of her usage. She disclosed she took a large amount of pain killers and was struggling with her mental health due to her past. She did not disclose any further information regarding this; however, she told the worker she was "*mentally fucked up in the head*" and explained how she had sent her mum a video of her cutting her arms and taking an overdose. She felt no mental health professional was supporting her and she was waiting for the mental health worker to make contact. Becky added she had MS and asthma, she also disclosed she was 'sleeping 'with 2 different men and called herself a '*slut*' (no details were taken of the men). A further appointment was made the following week; however, this was cancelled by Becky due to her feeling unwell.

16.3.36 Debbie recalls that Becky called after she had cut herself rather than send photos or videos. When Debbie arrived at Becky's home, she could hear Male C shouting '*why have you done this?*'. Once in the flat, she described blood being everywhere, especially in the kitchen. Becky's arm was cut was to the bone, Debbie's was able to provide Becky with medical help. Male C offered to take Becky to the hospital, but Debbie insisted he called for an ambulance as she was concerned, he would not be able to care for her whilst driving. After Debbie had treated the cut, the ambulance was cancelled, and Male C was able to take Becky to the hospital. Due to the children returning the following day Debbie cleaned the flat. According to Debbie whilst in hospital Becky took photos of her injuries and showed her eldest child.

16.3.37 The substance misuse worker emailed the social worker asking for an update regarding mental health support but was informed this had been closed due to non-engagement. They set themselves an action to offer mental health support to Becky and re-refer.

16.3.38 At the beginning of October 2021 Becky attended hospital with abdominal pain reporting she had been hit by a car 10 days earlier, the hospital was concerned regarding the level of bruising over her body and referred her to children social care.

16.3.39 During a FSG group supervision in mid-October concerns were raised that Becky may be in a domestic abusive relationship with Male A. Becky had disclosed to the social worker that Male A was controlling, she attributed bruising on her body to rough sex (this has been recorded as consensual) and told them she was "*nothing*". She informed them the relationship had ended but had now resumed and she would be putting in some boundaries (it is unclear if this was the ex-partner who had been harassing her in June 2021). An action from the supervision was given for the social worker to explore domestic abuse with Becky. A DASH was not completed, and it is unclear what safety work was carried out and whether the domestic abuse was discussed further.

16.3.40 At the end of October, the substance misuse worker contacted Becky, she reported she was struggling with her mental health and had been drinking more, she agreed to start the 'Managing Alcohol Program'.

16.3.41 At the beginning of November 2021, the children stayed with Charles and Debbie due to Becky struggling to care for them because of her mental health and substance misuse. She told children social care that she had ended her relationship with Male A, and he had been threatening and harassing her. No DASH or safety work was completed and there was no offer for a referral to the domestic abuse worker within FSG or to call the Police.

16.3.42 A home visit was completed by the substance misuse worker where Becky reported she was not doing well, was smoking cannabis, and drinking daily and the children were with her mum for as long as she needed them to be there. She told the worker it would have been better if she killed herself and knew what she would need to do should she need to. She disclosed she and her mum had received threats from an ex-partner – Male B (not Peter or Male A). She stated he had not been violent but was controlling. Her mum had identified these behaviours, raised it with Becky and this is why she had ended the relationship. Becky was provided with a lock box for the cannabis and helpline numbers. The substance misuse worker informed Becky that she would update the social worker and mental health worker (this was completed via email). No DASH was completed, no discussion of domestic abuse support or report to Police.

16.3.43 A further CiN meeting was held in mid-November 2021 with a focus on Becky's alcohol consumption, her feeling low and depressed, which was causing her physical pain (there was no medical evidence for this pain). Domestic abuse was not raised or discussed at any stage within this meeting even though there had been 2 disclosures and 2 different perpetrators.

16.3.44 Three days after this meeting, a social worker visited Becky, who was drinking alcohol, she stated she had increased her drinking due to the stress caused by her ex-partner (it is unclear if it was Male A or Male B) who continued to send her threatening messages. No DASH was completed, no offer for a referral for domestic abuse support or to report to the Police. The children were spoken to by the social worker (they remained with their maternal grandparents) who told them: Mum was poorly and needed to "*sort her head out*".

16.3.45 During December 2021 there are 5 contacts with children social care, these consisted of:

16.3.46 Concerns raised by the youngest child's school as they had not attended school and Becky was not responding. Becky was spoken to and reported to have slept all day after taking sleeping

tablets and had been unable to care or take her youngest child to school. Her eldest child got herself ready and walked themselves to school.

16.3.47 Becky had a face-to-face meeting with her substance misuse worker telling him that the children were living with her, and she was angry that children social care had asked Debbie to foster the children. However, Debbie stated this was not the case and social care had asked for the children stay with them if Becky was in crisis or the children need a safe place.

16.3.48 A further CiN meeting was held, Becky disclosed she had cut her wrists over the weekend whilst the children were with Peter.

16.3.49 Charles contacted children social care and raised concerns that the eldest child had bruising to their upper arms, they had disclosed that Becky had done this when she was drunk and as a result the children stayed with Debbie and Charles for several weeks.

16.3.50 In mid-December 2021, a strategy discussion was held in response to concerns regarding Becky's mental health, her use of alcohol and substances and the impact this was having on her care for the children. There were also concerns regarding a male who was found at Becky's home (no details were available for the review of who this person was, what possible risks he posed or their relationship status). Charles and Debbie offered to care for the children, but Becky declined this offer. Charles and Debbie were assessed for potential carers for the children, and it was agreed for a Section 47 to be completed. A Child Protection Conference was held, Becky, Peter and Charles were all present and the children were placed on a Child Protection Plan in January 2022 under the category of neglect.

16.3.51 In a core group meeting at the end of January 2022 (Becky, Charles and Peter were in attendance), Becky shared she was in a new relationship with Male C and was feeling positive about it. An action was made for the eldest child to be referred to the 'Hidden Harm' worker within SDAS and for the social worker to complete healthy relationship work. This work commenced at school in mid-February 2022.

16.3.52 At the next core group meeting Becky, Charles and Peter attended. Concerns were raised that Becky had shown her eldest child her self-harm wounds as Becky had thought they had wanted to see them. There were also concerns the eldest child was not attending school due to bullying from boys at the school via a WhatsApp group. An action was set for the Hidden Harm worker to speak to the child and explore support and intervention.

16.3.53 SDAS continued to support Becky and her eldest child throughout March and April. During her sessions Becky disclosed she had used alcohol from an early age, that her relationship with Male C was good, they were getting on well, he was getting on with the children and was supporting with parenting. The eldest child was being supported in how to manage their anger and how this affected others. They had also spent time with their father and his family which they really enjoyed (it is unclear if this was their biological father or Peter).

16.3.54 At the end of March, a further Child Protection Conference was held which Becky, Peter and Charles attended, it was agreed the children would remain on the plan under the category of neglect. The social worker had completed one session of healthy relationships, but no detail was provided.

16.3.55 At the beginning of May, Becky told her substance misuse worker that she had begun to engage with the Community Mental Health Team, and she felt positive about it.

16.3.56 Charles was killed by Peter and Craig in Mid-May.

17. Analysis and Learning

17.1 Throughout this review the panel have tried to ensure the report is proportionate in the response to those involved, however, due to the extensive information on Becky the analysis has focused on identified key themes regarding her and the domestic abuse.

17.2 *Charles's role in Becky and the children's life*

17.2.1 Charles was loved greatly by Debbie, his family, the children, friends, and colleagues. He was also caring to Becky and the 2 children, was a supportive and prominent member of any meetings and action plans. He supported Becky when she was in abusive relationships, when her mental health deteriorated, or her alcohol intake increased especially when offering a place to stay and facilitate childcare or contact. Due to his role within the family, he provided stability for the children and a place of safety.

17.2.2 From discussions with family and with professionals who were involved with Charles it does not appear he was ever concerned for his own safety from Peter, Becky, or any other person. Even though he had been subjected to verbal and physical assaults by Becky he remained supportive of her throughout.

17.2.3 Charles was clearly aware of the domestic abuse and sought to support Becky and Peter in the raising of the children. From discussions with Debbie, Peter, and social care he was a fundamental member of the family supporting Becky and providing consistency when there was chaos and disruption. When there is domestic abuse within a family there are wide reaching implications not just to children but also wider family members. It would be beneficial for all of those involved with families to be aware of the 'ripple affect' from domestic abuse.

17.3 *Impact of trauma and victims coping strategies*

17.3.1 Becky had witnessed domestic abuse as a child and was a victim of domestic abuse as an adult. Becky had also experienced several other Adverse Childhood Experiences (ACEs) which impacted in her relationship with her family, intimate partners, and professionals.

17.3.2 There are two types of trauma; Complex Trauma[15]; involves a person experiencing repeated traumatic events over a period of time with each traumatic event compounding the impact of previous trauma experienced and because of the repetition, there is little to no time for recovery between incidents. Post Traumatic Stress Disorder (PTSD)[16]; involves a person experiencing a single traumatic event, which the person has time to recover from. A person experiencing Complex Trauma typically, would have trauma related symptoms such as flashbacks, sensory triggers, panic attacks, anxiety, depression, suicidal thoughts[17]. Given what is known of Becky's life experiences, and the information provided there is the likelihood Becky was and may well still be experiencing Complex Trauma. When a person has experienced abuse there is a 'trauma impact' recovery, dependent on how regulated a person is at the point of impact, support available to them, the traumatic event and context in which it is experienced.

[15] https://uktraumacouncil.org/trauma/complex-trauma
[16] https://www.nhs.uk/mental-health/conditions/post-traumatic-stress-disorder-ptsd/overview/
[17] https://www.amazon.co.uk/Trauma-Recovery-Aftermath-Violence-Political/dp/B00M0DB53G

17.3.3 When a traumatic event occurs a person's responses are unconscious and instinctively driven. When a person feels or senses fear the Amygdala in the brain senses risk to self and triggers the release of cortisol and then adrenalin to prepare the body for response in Fight, Flight, Friend, Freeze or Flop[18].

17.3.4 Whichever response is triggered, places a person into either a state of Hypo-arousal or Hyper-arousal[19], and their Window of Tolerance[20] is reduced, significantly reducing a person's ability to function in everyday life.

17.3.5 Some people with Complex Trauma can become trapped in a stress response leaving them in a constant state of hyper-vigilance. When Becky presented to agencies and her family, she could be disruptive, argumentative, uncooperative, under the influence of substances or alcohol and have 'mental health' issues, to name but a few. When you consider Becky's behaviour towards all of those around her and the trauma, she had experienced it would suggest she was in a state of Hyper-arousal.

17.3.6 Victims of trauma can present as chaotic and in crisis, defensive, aggressive, withdrawn, with little capacity for clear thought, physiologically. This is referred to as the Window of Tolerance (see 17.3.4.) meaning they may experience a reduced capacity state. Victims of trauma will seek safety in places or with individuals where there is known danger rather than an unknown place/individual where unknown dangers could exist. A person functioning in this way whilst under the scrutiny of the authorities, agencies, or peers, would typically feel they are under attack and will retaliate and respond in whichever way looks to them the most successful to preserve self - unconsciously, as described in Judith Herman's[21] quote:

"When neither resistance (fight) nor escape (flight) is possible, the human system of self-defence becomes overwhelmed and disorganised. Each component of the ordinary response to danger, having lost its utility, tends to persist in an altered and exaggerated way long after the actual danger is over."

17.3.7 The impact of trauma typically, creates feelings of worthlessness, low confidence, and self-esteem, helpless, hopeless and fearful. Becky used derogatory language to describe herself as a '*slut*' and '*nothing*'. This indicates her lack of self-worth, not seeing herself as worthy of better and in this scenario would be described as 'free falling'[22]. It is disappointing there was no apparent work or discussion investigating why Becky felt this way and how she could have been supported to understand her feelings and therefore enhance her support and recovery.

17.3.8 Given Becky's experiences, falling from one crisis to the next is typical of a person in trauma and whose life was chaotic. Becky struggled to make informed, safe, and healthy choices for her and her children, even though it is likely, that her intentions were otherwise. Her intimate relationships were all abusive and had a significant impact on her mental health. Victims cannot be blamed for their choices especially when they are in a trauma response state which will result in choices not being entirely their own. Victims should be given the equality of opportunity and ability to understand what options are available when working with services, rather than victims feeling agencies are working against them.

[18] https://www.zoelodrick.co.uk/
[19] https://traumathrivers.com/more-on-hyper-and-hypo-arousal/
[20] https://www.nicabm.com/trauma-how-to-help-your-clients-understand-their-window-of-tolerance/
[21] Trauma and Recovery, by Judith Herman (1992) - Not Even Past
[22] https://emotionalgranularity.com/index.php/2019/08/20/freefall/

17.3.9 Becky had significant dependence on alcohol. The Institute of Alcohol Studies[23] found that alcohol use with victims is complicated, and they may turn to alcohol as a means of coping with their experiences of abuse. The Institute also found alcohol plays a significant part where both partners engage in violence, which was evident in the relationship with Peter.

17.3.10 The study highlighted that typically between 25% and 50% of those who perpetrate domestic abuse had been drinking at the time of assault. In some studies, the figure is as high as 73%. Cases involving severe violence are twice as likely to include alcohol and when alcohol is involved in domestic abuse, evidence suggests it is not the root cause, but rather a compounding factor. Peter had been drinking when he assaulted Becky in 2014 and 2020 and when he killed Charles. All of these incidents included high risk behaviours resulting in Becky being injured and ultimately Charles losing his life.

17.3.11 The recent Domestic Homicide Oversight Report 2023[24] found that of the DHRs in 2020 – 2021 61% of victims had a vulnerability and of these vulnerabilities 34% were mental ill health, 28% problems with alcohol and 22% illicit drug use. Of those that had a mental health vulnerability, 15% had suicidal thoughts, Becky was experiencing all these vulnerabilities, yet services were not taking the domestic abuse into account when they were presented with these behaviours.

17.3.12 Services were aware of Becky's poor mental health, which may have been from her childhood and from her abusive relationships. Safelives[25] found in a study that people with mental health needs were more likely to experience all forms of domestic abuse than those who did not. They were also more likely to have drug and alcohol misuse problems.

17.3.13 Becky regularly self-harmed and made attempts to take her own life, according to the Safelives report 43% of victims who had mental health needs had self-harmed or planned/attempted suicide.

17.3.14 Safelives summarised their findings:
There is a link between domestic abuse and mental health problems Mental health problems are a common consequence of experiencing domestic abuse, both for adults and children. Having mental health issues can render a person more vulnerable to abuse. It is therefore perhaps unsurprising that a significant proportion of people accessing mental health services have experienced abuse. Despite these strong associations, domestic abuse is often going undetected within mental health services and domestic abuse services are not always able to support people with mental health problems.

17.3.15 When considering all these different traumas and responses it is essential services work not only together but with the 'client' to avoid re-traumatisation and ensure the clients voice is heard.

17.3.16 SDAS introduce Trauma Informed Care via e-learning which also covers ACES. Although this is an introduction it is detailed with several videos to enhance learning. Staff are expected to complete the e-learning prior to attending the half day face to face training. This training appears to be at an appropriate level for staff, however, it is not mandatory which is being reviewed due to this report.

[23] https://www.ias.org.uk/wp-content/uploads/2020/12/Domestic-abuse-sexual-assault-and-child-abuse.pdf
[24] https://www.gov.uk/government/collections/domestic-homicide-review
[25] Spotlight 7 - Mental health and domestic abuse.pdf (safelives.org.uk)

17.3.17 SIDAS provide Trauma Informed Care training to all their frontline staff, and it has been embedded within its documents, assessments, and support plans.

17.3.18 There is little understanding of the impact of domestic abuse on Becky's children, especially as they were subject to statutory child protection procedures. Children social care run Trauma informed practice CPD sessions throughout the year for the workforce. There is also e-learning through the Safer Somerset Partnership that is open to all staff. Trauma informed approach is a thread that runs through all social care training. The family safeguarding team are reviewing how they can ensure this is fully understood and implemented with the families in receipt of support.

17.3.19 Avon and Somerset Police provide different training packages with Trauma Informed interwoven throughout to ensure all those who come to their attention are provided with a holistic and person-centred approach.

17.3.20 Trauma Informed Practice is central to how we engage and work with the most vulnerable in our society. It is positive all the agencies who were involved in the review have this available through specific training or within other training packages. It is essential that these organisations continue to review individuals practice and ensure there is a comprehensive understanding of this approach.

Learning Point 1
Becky has experienced ACEs and trauma throughout her entire life which has impacted on her mental health, her misuse of substances and her responses to her family and agencies. Agencies need to be able to understand trauma responses, how to provide trauma informed practices and how to support for successful and positive outcomes.

17.4 Unconscious Bias[26] towards victims and the impact of agency responses.

17.4.1 Becky, Peter, her children, her partners, and the wider family were known to services with repeated concerns for welfare and safety for over 10 years with the main focus on Becky and her behaviour rather than the possible causal factors.

17.4.2 Previously the term 'Toxic Trio'[27], would have been used to describe the co-occurrence of domestic abuse, substance misuse and mental health. It was used to be able to support professionals in their response to the parent, however over recent years this term has been identified as narrow and does not acknowledge the wider complexities faced. A 2020 study from the National Children's Bureau, the University of Kent and the University of Cambridge found that there was little robust research or evidence to quantify whether a combination of the three factors resulted in an increased risk of abuse or neglect. The NSPCC[28] describe how when practitioners who only work within these 3 heading miss other contributing risk factors which may be 'Parental ACEs' and 'Barriers to working with agencies' and 'Trauma' (all of which Becky had experienced), it is now called the 'Trio of Vulnerability'.

17.4.3 The FSG's main focus was on Becky's substance misuse and her mental health, with little recognition of domestic abuse or the additional trauma's she had experienced as a child,

[26] https://www.ed.ac.uk/equality-diversity/students/unconscious-bias
[27] https://www.highspeedtraining.co.uk/hub/what-is-the-toxic-trio/#:~:text=The%20'toxic%20trio'%20is%20made,harm%20to%20children%20has%20occurred
[28] https://learning.nspcc.org.uk/news/why-language-matters/how-toxic-trio-is-unhelpful-and-inaccurate

young person, or adult. Although an action was set for the social worker to go through 'Healthy Relationships' only 1 session was completed, and it is unclear what was discussed. Those who are subjected to domestic abuse are in unsafe rather than unhealthy relationships. Any person subjected to abuse needs those working with them to understand this so they can provide them with the opportunity to understand abusive patterns, recognise the signs and where to seek support and intervention in a safe way. From the response of those working with Becky there appears to have been little awareness or understanding of risk and how to support her with regards to the domestic abuse.

17.4.4 When the family was placed on a CiN Plan only a drug and alcohol and mental health worker was allocated to her. Children Social Care informed the panel that Becky's priority was her drinking and mental health, but there is no evidence that a domestic abuse worker was offered. Although we do not want to overwhelm those who are vulnerable the offer must always be made to enable choice. This was a missed opportunity for partners to work together to identify risk, seek solutions and support Becky in her recovery and future.

17.4.5 In subsequent meetings the continued fixation on Becky's behaviour regarding her mental health and her use of alcohol resulted in the family being escalated to a Child Protection Plan. Becky disclosed to her social worker she was experiencing controlling and coercive behaviour and sexual violence which had resulted in bruising from her new partner (Male A). Although she stated the sex was consensual the social worker did not use their professional curiosity to explore this further, offer support or complete a DASH. Sexual violence and coercive controlling behaviours are high risk factors within an abusive relationship. Any disclosures of this kind should be taken seriously, and further potential risk explored.

17.4.6 When the social worker raised the domestic abuse at the group supervision there was no discussion of introducing a domestic abuse worker, what the risks were or how this may be impacting on Becky. Although there was an action for the social worker to explore further domestic abuse, there is no evidence this took place. With this lack of positive action or appropriate risk assessment by the social worker, other practitioners involved or the manager leading the group supervision it indicates a lack of awareness and knowledge of domestic abuse, risk factors and interventions.

17.4.7 Within a month of the disclosure, Becky made a further statement regarding her deteriorating mental health due to separating from her abusive partner who was threatening and harassing her. The high-risk factors identified within these two conversations were: injuries, impact on her mental health, separation, threats, coercive control, harassment, and previous sexual assault. Still no DASH was completed which would have been expected, appropriate support offered, and referrals made. These disclosures could be considered a 'cry for help' but on both occasions her voice was not heard and there were missed opportunities to have actively involved her in any safety planning.

17.4.8 Becky went on to make a further disclosure to her SDAS worker of abuse from another ex-partner (Male B). Again, the DASH was not completed, and no domestic abuse support offered. Without the DASH being completed and further exploration of the situation neither the social worker or SDAS worker were able to complete a full and robust risk assessment. Becky is a repeat victim of domestic abuse with additional vulnerabilities and although there were practitioners involved at no point were these 'joined together' to create a whole picture of Becky's past, current and future relationships.

17.4.9 The panel identified that the FSG social workers and specialist workers do not complete a DASH RIC and are heavily reliant on the domestic abuse workers to carry these out. If there are concerns of domestic abuse by either the SDAS worker or mental health worker, they refer to the social worker to act. The issue with this case is that no action was taken, and the domestic abuse worker was never approached or involved and therefore could not complete the required risk assessment. Becky had reached out to those working with her, her voice and concerns had not been heard due to the possible unconscious bias of those around her with regards to her behaviours and their preconceived perception of her.

17.4.10 It appears the agencies working with Becky continued to focus on her mental health and substance misuse rather than the context and environment behind the presenting behaviours. This attitude continued in the Child Protection meetings firstly with Peter being invited when Becky was also present and had no support. Services were aware that Peter had been extremely violent to her, had exerted power and control throughout their relationship and after it had ended. Peter was considered a protective factor to the children even though he had been abusive in front of them, and Becky (the victim of his abuse) was considered the risk. All of Becky's vulnerabilities were shared with Peter who would have had the opportunity to continue to exert his power and control over her.

17.4.11 Peter's presentation to agencies is not unusual, perpetrators of domestic abuse will at times present as the protective parent, they will manipulate the narrative stating their victims (prominently the mothers) are 'mental' and that they are there in a supportive role. The impact on victims can be devastating and can appear that agencies are colluding with the abuser, leaving them isolated and not heard. This can drive victims to stop engaging and seek solutions in other ways (such as new relationships or further substance misuse).

17.4.12 Staff may not have been aware of their unconscious bias as it can impact on how they respond to those they work with and ultimately effect the support they offer. We all have unconscious bias which comes from unconscious stereotypical associations of people and the circumstances surrounding them. Unconscious bias can lead to victims being blamed for the abuse, the choices they make and the outcomes of their decisions. Becky was considered disruptive, a risk to her children, making unsafe choices, not addressing her mental health, not engaging with services, and using substances. With these factors in mind the focus remained solely on Becky as the problem rather than what the causes were contributing to these behaviours, not only by professionals but also her family. It is difficult to prove this and is in no way to blame the practitioners of their actions, however, everyone needs to be aware of their biases and how they can overcome them.

17.4.13 Once practitioners understand any potential bias, they can be aware of the impact it has on the stance they take with regards to each parent/client. For those working with vulnerable people it is essential practitioners aim to take a neutral stance with the information presented. Those working with Becky appear to have taken an accusatory stance, she was blamed and seen as the 'problem'. Whereas it appears that a collusive stance was taken with Peter, he was seen as a protective factor and was able to present himself as a caring father and ex-partner. This imbalance can be dangerous and those working with vulnerable people and perpetrators need to understand how they respond and react to make neutral and well-informed decisions. Practitioners would benefit in having training and confidence when faced with dual allegations and perpetrators presenting as caring parents or as the victim. Somerset Council have commissioned training in 2023 and to deliver training due to similar DHR recommendations.

17.4.14 From the information provided there is indication of Selective Evidence/Confirmation Bias, Premature Termination of Evidence bias, Repetition bias, Dichotomous bias, Source bias (this one is notably prevalent) Incremental Decision-Making bias and Illusion of Control bias amongst agencies with this family (See Appendix 1).

Learning Point 2
Judgements and decisions influenced by unconscious bias can result in decisions being made with inaccurate, misplaced, and incomplete evidence. Agencies need to understand the relevance of unconscious bias in their practices and decision-making, which would enable a less punitive response to victims and less collusive reaction to perpetrators.

Learning Point 3
There were multiple missed opportunities within the family safeguarding team to have explored Becky's relationships in further detail, risk assess, make referrals, offer support, and seek guidance from the domestic abuse workers. Failure to do this increased Becky's risk not only from her ex-partners but also herself due to the impact of the trauma experienced.

Learning Point 4
The family safeguarding team are reliant on domestic abuse workers to complete the DASH which creates a barrier when there is no domestic abuse worker involved with the family, this creates missed opportunities to appropriately risk assess and safeguard victims.

17.5 Response by agencies and the offer of interventions to victims of domestic abuse

17.5.1 The contact with Avon and Somerset Police between 2012 and 2016 even though outside the review period enabled the panel to have clearer understanding of the relationship dynamics between Peter and Becky. It highlighted the presence of trauma bonding[29] from Becky to Peter, Becky's coping strategies as well as her management of risk; in a context where she had no control. From childhood and throughout her adult life we can assume the probability of Complex Trauma Becky experienced. The Police acknowledged, that had all fourteen events been viewed and acted on under today's law, practices and understanding of trauma and domestic abuse would have caused their intervention to look very different.

17.5.2 Peter used high risk violence and non-violent behaviours towards Becky, including ten High Risk factors[30]; Assault (headbutt), Injury (bruising), Threats to kill, Coercive Control, Alcohol, Separation, Pregnancy, Escalation, Sexual Assault and Strangulation. Peter also demonstrates significant rigid distorted beliefs, he used repetitive abusive behaviours, had a lack of respect for Becky, the children (violence and aggression when they were present) and the authorities. He had and continues to have a lack of remorse, and an absence of accountability, using collusive behaviours to manipulate professionals. All these increased Becky's risk not only from him but others and herself.

17.5.3 Each time the incidents were dealt with in isolation, however when we bring them together and consider high risk factors and clusters this forms a clearer indication of potential levels of risk, as well as appropriate preventative actions. It is unclear from the reports by officers if there was a lack of knowledge of these risks or it was attitudes at the time.

[29] https://www.verywellhealth.com/trauma-bonding-5210779
[30] https://library.college.police.uk/docs/college-of-policing/Risk-led-policing-2-2016.pdf

17.5.4 It is positive that the Police arrested and successfully convicted Peter in 2014 for the assault on Becky, they were proactive with their attempts to continue with an evidence led prosecution, referred the children to the Multi- Agency Safeguarding Hub on each occasion and referred to MARAC.

17.5.5 To support Police, Avon and Somerset have undergone the Safelives DA Matters[31] training in 2023 with the aim to upskill officers in their understanding of domestic abuse, its complexities, coercive control, how to gather evidence and identify victims and perpetrators. Within this initiative there are also DA Influencers who are supporting officers and help make change within the force to ensure victims are not blamed for their abuse and officers are confident in their responses.

17.5.6 In summary There was a lack of multi-agency response across agencies (police, children's services and domestic abuse services) to domestic incidents. There were missed opportunities to undertake DASH risk assessments, importantly a failure to refer to MARAC.

17.6 Information Sharing

17.6.1 It is encouraging the Police identified Becky as a high-risk case, referring it to North Somerset MARAC and there was positive engagement of services at the meeting. The action regarding the MARAC-to-MARAC referral was not completed. However, the other action for Becky to engage with domestic abuse services was completed with a referral to SIDAS. Unfortunately, without the MARAC-to-MARAC referral there was a missed opportunity for agencies in Somerset to have had information regarding the risks to her or the children. There is currently no oversight of actions created at MARAC and there is little that can be done to hold agencies to account. This remains a challenge across the country with a reliance on these being completed without any assurance.

17.6.2 NextLink coordinated the MARAC when Becky and Peter were heard and continue to coordinate the MARAC. The MARAC-to-MARAC process for North Somerset is part of the MARAC Protocol (5.13). 5.13.2 states:
Referrals to another MARAC,

- *If an agency becomes aware that a case which reaches the threshold or an existing case has moved either temporarily or permanently to another area a MARAC to MARAC referral should be completed Appendix 6 – SafeLives MARAC to MARAC Transfer Form and sent to the MARAC Administrator for transfer to the appropriate MARAC.*
- *Agency representatives should liaise with counterparts in the new area to fulfil any responsibilities to the parties involved.*

Learning 5
There is no advice or guidance within the North Somerset MARAC protocol regarding who takes responsibility to complete a MARAC-to-MARAC transfer when it is as an action from the meeting. It is essential that MARAC actions are SMART and identifies who will complete them.

17.6.3 Somerset have recently introduced a new MARAC protocol and process which is clear with regards to the MARAC-to-MARAC referrals. if it is set as an action within the meeting it is completed by the MARAC team which is overseen by SIDAS. However, if a victim moves out of area and has been heard at MARAC and agencies are aware of this it is the agencies

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

responsibility to make a referral to the relevant area. All agencies who attend and signed the Somerset MARAC Protocol are aware of these expectations.

17.6.4 The SIDAS IDVA involved with Becky, had positive engagement, and kept the social worker in North Somerset and housing up to date. However, there appears to have been a lack of information shared with them by social care regarding the MARAC, substance misuse and mental health.

17.6.5 The IDVA appropriately risk assessed, safety planned, offered target hardening, and civil legal options, all of these were consistently reviewed throughout the support (including when circumstances changed). These reviews and file audits were all completed within contractual time frames, and policies and procedures.

Learning Point 6
Information sharing across borders and amongst agencies is key to be able to appropriately risk assess and offer support to those who are vulnerable. The MARAC was proactive in their action for the MARAC-to-MARAC transfer however, due to there being no 'check and balances' to ensure actions are completed this opportunity was lost. It is difficult to identify who the responsibility would lie with regarding quality assurance of cases as MARAC is not statutory.

17.7 Further exploration of injuries

17.7.1 Becky attended the hospital with significant bruising stating she had been hit by a car. Due to the review not having access to her medical notes it is unclear if these injuries and her account was explored further by medical staff. It is positive that they referred to children social care. Unfortunately, there is no evidence to suggest social care explored the incident or the injuries with Becky or raise it at the group supervisions. This is concerning as they were aware of her new abusive relationship, she had been seen with visible bruising from sexual violence and she had made disclosures of coercive control. This was a missed opportunity to build a picture of Becky's current circumstances, any risks, and possible interventions.

Learning 7
Professional curiosity was not used to explore what Becky was experiencing, complete any risk assessments and review support.

17.8 Domestic Violence Disclosure Scheme (DVDS aka Clare's Law)

17.8.1 There were several missed opportunities for agencies to have considered a DVDS with regards to Becky's new partners.

17.8.2 The Police raised concerns with social care that she was in a new relationship with a male known to them and she was identified as vulnerable. Social Care were also made aware of a further two relationships, one of which she had informed that he was emotionally and sexually abusive. Additionally, the IDVA and SDAS workers were aware of other relationships including the final one before the Charles was killed. There appears to have been no professional curiosity shown into who these men were and the risks they may have posed to Becky and the children.

17.8.3 The panel recognised that all four services missed this opportunity to have either discussed the disclosure scheme with Becky or to have made an application. Although we cannot be certain Becky would have accepted a disclosure by the Police or ended these relationships, she would have been provided the information to have made an informed decision.

Learning Point 8
Agencies are to consider discussing and requesting a DVDS when a vulnerable person is in a new relationship and there are concerns for their safety.

17.9 Contact with victims

17.9.1 NextLink's policy is to make 3 attempts for engagement and then close. They made 5 attempts to contact Becky, with 1 partial successful contact. Although it is positive that they exceeded the required attempt for contact there was an opportunity to have used alternative methods of contact (such as text/WhatsApp/email). There was also an opportunity for them to have contacted the social worker to carry out a joint appointment. The lack of contact was shared at MARAC, and this was an opportunity for an action for the social worker to offer and arrange a joint appointment with the IDVA.

17.9.2 SIDAS were also proactive in contacting Becky starting within 48 hours of receipt of the referral, they were able to complete an initial assessment 2 days later. This is a quick response and positive that from the referral, DASH and initial assessment Becky required an IDVA rather than an outreach worker.

17.9.3 When Becky was referred to SIDAS her DASH score was 7 however, the IDVA completed a DASH with a score of 13 with identified high risk factors including recent strangulation and separation. Best practice would have meant a referral to MARAC should have been made, it is unclear why this did not happen.

17.9.4 There were lengthy gaps of no contact, with no explanation, and recorded evidence of future appointments made. This is not in line with good practice, whereby contact should be weekly (or evidenced as to why not) and future appointments must be made after a support session. The role of COVID restrictions, throughout the year, impacted on the delivery on face-to-face meetings, and support sessions. There was a reliance on text messages, and phones calls, which impacted on the frequency of meetings.

17.9.5 When the case was open to Somerset Children Services and the FSG, they were unaware of any previous involvement with SIDAS which was a missed opportunity to have worked together and support Becky. Additionally, there was no discussion with Becky around a referral to SIDAS CYP (Children's and young persons) team for the children as they had witnessed domestic abuse. Although the eldest child was offered and engaged well with the SDAS Hidden Harm worker this was a further missed opportunity to have provided choice and options to the family.

17.9.6 COVID and lockdowns was experienced throughout some of the contact and review period, and we cannot underestimate the impact this had on service delivery, response and for those who lived in abusive situations. This may have impacted on the interaction with Becky from services as there were less face to face appointments being offered, however the review has been unable to determine if COVID impacted Becky.

Learning Point 9
When completing the DASH RIC, practitioners are to be aware of high-risk factors and clusters to enhance their professional judgement when considering referrals and signposting.

Learning Point 10
Although contact and engagement with the IDVA was good this was inconsistent, with no further appointments scheduled or written explanation for these inconsistencies.

18. Recommendations

Recommendation 1
Safer Somerset Partnership to evaluate their training offer which includes:

- ACEs.
- Trauma Informed Practice.
- Unconscious bias.
- Domestic Abuse Disclosure Scheme.
- Counter Allegations.
- Professional Curiosity.

Recommendation 2
Where there is possible domestic abuse, FSG workers are to obtain consent from the non-abusive parent, discuss at group supervision and seek consultation with the specialist domestic abuse worker with regards to risk and intervention.

Recommendation 3
All family safeguarding practitioners when identifying domestic abuse through assessment should be confident and competent in completing the DASH in advance of forwarding to specialist domestic abuse support.

Recommendation 4
MARAC to have the same statutory framework as other conferences where vulnerable people's safety and wellbeing are discussed to ensure tighter and robust accountability for actions and sharing of information.

Recommendation 5
All agencies to ensure those completing the DASH understand any cases where there has been Non-Fatal Strangulation is a high-risk factor and is to be referred to MARAC with detail provided within the risk assessment.

Recommendation 6
SIDAS to have contact with clients weekly and future appointments to be offered to clients after each support session. These are to be evidenced on the case file with explanations provided if this is not achievable.

Recommendation 7
North Somerset MARAC Protocol, section 5.13 (MARAC to MARAC transfer) to be amended and include: *'when an action has been identified within the meeting for a MARAC to MARAC transfer the lead professional for this is the MARAC coordinator and this is to be completed within 48 hours of the meeting'*.

19. Conclusion

19.1 There is no evidence to show that Charles had any direct involvement regarding the domestic abuse, other than offering support and a home to his partner, Becky, his grandchildren, as well as being supportive with the contact of the children and Peter.

19.2 Charles was a hardworking man who was loved by his friends and family, and he lost his life by those he knew and trusted. As demonstrated within this report Charles had never come to any attention of the authorities and was healthy (apart from experiencing COPD) and therefore there has been very little information regarding him for the panel to analyse.

19.3 However, due to the personal connection between Charles, Peter, and Becky we have had the opportunity to be able to explore the interactions of agencies with Peter and Becky in a hope we can support good practice and missed opportunities. It has been a difficult DHR to complete as we wanted to ensure Charles was not lost in any of the report and are conscious the focus is on Becky and Peter. There have been repeated missed opportunities that have impacted this family and cannot be overlooked.

19.4 This family had come to attention with the Police and Childrens Social Care for over a decade and although there have been changes to practice, policy and legislation over this period the panel have been able to identify areas of improvement outside of these aspects:

- The absence of professional curiosity,
- Effective information sharing including across borders,
- Lack of understanding of domestic abuse and the complexities for those subjected to it,
- Fragmented interventions as well as collusion with Peter in accepting him as protective factor for the children, whilst Becky was not,
- Proportioning the blame on the abused Mother rather than focusing on the causal factors,
- Lack of the DASH RIC being completed after disclosures.

19.5 However, there were proactive measures put in place:

- Police arresting Peter, obtaining a successful conviction, and seeking evidence led prosecution,
- Police continuously treating Becky as the victim,
- The children's safety identified as being at risk,
- IDVA's review of DASH and support plans.

19.6 Many of the key learning points identified in this review have already been recognised in other reviews across the county, the Domestic Homicide Review – Learning from Somerset's Cases (2017), noted 'the need for developments in practice regarding domestic abuse cases where Toxic Trio (now known as Trio of Vulnerabilities) is present'.

19.7 Other areas noted were to improve practice, information sharing, cross border information processes across agencies, application of DASH RIC, agencies not working in silo, professionals lack of knowledge and understanding of the nuances of domestic abuse especially where violent resistance is present, meaningful referrals to specialist agencies, application of professional curiosity. All of these have been identified within this review, so the question we now must ask is: If these are reoccurring, how are we effectively making change? Somerset have developed a Domestic Abuse Strategy and have a board which aims to learn and make changes. Although some may be instant others are systemic and a cultural shift which will take time to ensure it is done correctly and only once. To ensure learning and change happens across the entire workforce DHR's are to be shared in workshops and learning events to avoid these tragedies from happening again.

19.8 We as a panel cannot imagine the pain and the hole this devastating tragedy has created for those who have lost their husband, brother, grandfather, son, friend, and colleague. Domestic abuse, domestic homicide and domestic suicide has far-reaching impacts not only effecting immediate family but also, extended family, and communities. This is why it is imperative that agencies apply the valuable learnings sought through this domestic homicide process and involve frontline workers, strategic partners and most importantly the communities, in their drive to make a difference.

Statement from the family

The family would like to begin by expressing gratitude to all those involved in this review, for their time and effort in gathering the required information and to the chairs for producing this report. Our appreciation goes to them for their support, kindness, encouragement and understanding. The part they played in getting us this far should not be underestimated.

It has been rather a long roller coaster ride which has taken a huge toll upon us all. However, having the opportunity to have a voice, and to finally be able to speak up for Charles, brings some validation.

Since Charles' life was taken, the family has endured endless anguish. Throughout the various court hearings, we endeavoured to maintain our dignity and composure - an extraordinarily difficult challenge given that we heard harrowing evidence and, at times, insulting statements - most notably from the defence teams. Thus, we listened to Charles' name being sullied whilst being denied any chance to protect his good character - relying on others to do so, or not…..

The family have largely felt ignored since the incident. Although, to be fair, we have no issues with the investigation itself and encountered some true gems along the way - the amazing people at Victim Support, brilliant counsellors and DC McFall from Avon and Somerset constabulary - without whom we would have sunk without a trace. The 'justice' system rarely seems to accommodate the victims or their families. However, providing feedback, relating to various departments, did result in a positive meeting with the DCI involved in the investigation.

Our desire to gain some vindication for Charles was bolstered by thoughts of him. The loss of this cherished family member, the constant heartache, giving us the incentive to press on. We hope Charles would be as proud of us as we are of him. We therefore now wish to reclaim the real Charles and not let his name be defined by the brutality that ended his life; rather we desire to remember the way he lived, loved and laughed.

As with our experiences during the legal process, even basic communication can make such a difference. The added distress caused by lack of contact leaves families feeling isolated, neglected, and invisible. Whereas often just a brief response can alleviate those negative emotions. This report indicates that better communication between the services/agencies would have resulted in a more positive outcome for Becky, her children and, therefore, all the family.

Whilst we recognise that most of the good work carried out by these vital, valuable services goes under the radar and we understand that workload, budgets etc can impact on proficiency, we implore those responsible for providing them to heed the recommendations contained herein.

How do professionals NOT truly realise the ongoing effect that so many missed opportunities have on families in such circumstances? Our lives are affected daily whereby simple tasks become mountains

to climb. With so much mental and emotional overload, exhaustion permeates everything. Any planning is impossible, normal thought processes non-existent - indeed the composition of this statement has been all consuming (albeit sporadic due to bouts of overwhelming fatigue) over a period of 7-8 weeks; much energy has been invested as it is important to the family to grasp the opportunity to make this contribution. There have been many areas to consider and our desire to convey our thoughts has not been aided by frequent lapses in clarity and concentration.

The extra pressure placed on our immediate families is a greater burden because, whereas previously helping them, we are rendered ineffective and in desperate need of their assistance. For the siblings, interaction with their children and grandchildren is much diminished, therefore many of us are missing out on precious moments to make new memories.

Yet for Debbie it is far worse - very little contact with her grandchildren, few updates, and no opportunity for any meaningful conversation with them. Albeit we appreciate the gravity of their situation and duly recognise that careful handling is required, it seems they are all being punished through no fault of their own.

Our inability to function means we are unable to work efficiently thus employers and colleagues are affected. For instance, Debbie has been signed off, due to anxiety, for 8 weeks with the possibility that she will not feel able to return to her current role. A job she loves, excels at, and where she is valued. Her employers have been exceedingly supportive throughout this ordeal. What a travesty.

Another example of consistently being overwhelmed and distracted is ongoing struggles to cope with paperwork causing missed payments which have, on occasion, resulted in fines. Friends are neglected, telephone calls and messages ignored, any necessary gatherings taking a toll - requiring longer recovery periods. Our wish is to see improvements within the relevant services/agencies in order that other families will not have to suffer in this way.

Bearing in mind Charles' actions and intentions regarding the grandchildren, we have serious concerns for their welfare and are anxious that they should be provided with all the appropriate support necessary through the coming years. Due to their vulnerability, the possibility that their circumstances could result in another generation allowing themselves to become involved in similarly abusive relationships is a terrifying prospect.

Becky too, despite her involvement in the death of Charles, requires the assistance denied to her for so long. We hope that those supporting Becky will remind her that she has been let down by biased attitudes and neglect of dutiful care whilst emphasising that help is available to her. After all, if she can overcome at least some of her problems, that will be to the benefit of all concerned - not least her precious children.

Reassurances are required confirming that attitudes and working practices will change, that recommended training procedures will be adhered to. Otherwise, we fear that this could just serve to highlight the futility of Charles' efforts to assist in improving the children's quality of life, making those violent actions even more devastating. Will those on the ground be allowed time to address issues within families as they arise, not be constrained - by pressure from above - on workload, time, finances etc Surely early intervention cannot only save much heartache but money too.

We wholeheartedly agree with the Chairs conclusions regarding Peter in that he hoodwinks professionals, is manipulative, seeks to blame others and shows no remorse - we have, ourselves, witnessed a similar display by Peter.

The words uttered by the Judge in her summing up at Becky's trial declaring, when finding Becky not guilty of Public Order Offence, "Debbie gave as good as she got'" …. Well, the family agreed, good on Debbie - faced by two thugs attacking her beloved fiancé, Becky shouting and screaming, how could Debbie know what would happen next? Who of us can imagine what Debbie was feeling! FEAR?? Desperation to protect Charles …….

Having felt largely invisible throughout court proceedings, the Judge's acknowledgement (in her summing up) of the family's dignified behaviour made the effort of exercising much restraint worthwhile, another example of the positive impact of small, thoughtful deeds.
Sweet 'dreams' 'dearly beloved' Charles, we 'miss you' and whilst believing that 'love conquers all', we truly wish we could indeed 'wake you up when September ends' …….

Poem chosen by the family.

Goodnight to you dear Charles.
May the long-time sun
Shine upon you
All love surrounds you
And the pure light
Within you
Guide your way on
May the winds of love blow softly
And whisper for you to hear
That we will love and remember you
And forever keep you near
As here in this final act
In sorrow but without fear
Held in our hearts so dear
May you travel onwards in gentleness and joy
To find your peace
Deep peace to you
Deep, deep peace…..

Courtesy of Helen Salway-Roberts (celebrant)

APPENDIX 1 [32]

Selective evidence/confirmation bias: We tend to gather facts that support certain conclusions but disregard other facts that support different conclusions.

Premature termination of evidence: We tend to accept the first alternative that looks like it might work. Conflicting evidence is often not discounted but apparently just ignored (Munro, 1996).

Wishful thinking or optimism bias: We tend to want to see things in a positive light and this can distort our perception and thinking. We tend to provide recommendations as if the parties will live happily ever after

Choice-supportive bias: We distort our memories of chosen and rejected options to make the chosen options seem more attractive.

Recency bias: We tend to place more attention on more recent information and either ignore or forget more distant information (Plous, 1993).

Repetition bias: A willingness to believe what we have been told most often and by the greatest number of different sources.

Dichotomous thinking: We get stuck in validating specific claims rather than looking at big picture issues.

Source bias: We reject something if we have a bias against the person, organization, or group to which the person belongs: We are inclined to accept a statement by someone we like.

Incremental decision-making and escalating commitment: We look at a decision as a small step in a process and this tends to perpetuate a series of similar decisions.

Illusion of control: We tend to underestimate future uncertainty because we tend to believe we have more control than we have in reality.

[32] Decision Tree article.pdf

Domestic Homicide Review

Executive Summary

Somerset Community Safety Partnership

Charles died May 2022

Authored by Clare Walker
and
Katie Bielec

Completed October 2023

Published June 2024

Contents **Page Number**

Poem chosen by Debbie

l'm there inside your heart
I'm there
Right now l'm in a different place
And though we seem far apart
I'm closer than l ever was …..
I'm there inside your heart.

I'm with you when you grieve each day
And when the sun shines bright
I'm there to share the sunsets too….
I'm with you every night.

I'm with you when the times are good,
To share a laugh or two
And if a tear should start to fall ….
I'll still be there for you.

And when the day arrives
That we no longer are apart
I'll smile and hold you close to me ….
Forever in my heart.

Foreword

There is so much we could add about Charles although fundamentally his caring, compassionate nature shines through in this report. His inner strength is humbling, and we honour him for staying true to his beliefs no matter the adversity he faced. He was earnest in his concern for those in need. He took this to heart, acting in the best interests of those dear to him always attempting to improve their circumstances.

Charles was a kind and gentle man; he was committed to his partner Debbie and was a fundamental part of his siblings' lives. He had no children but loved Debbie's children and grandchildren as if they were his own. He enjoyed going on holiday with America being his favourite destination. He loved being at home, having tropical fish, completing DIY and having a quiet life in the heart of Somerset. He was described as someone who would help anyone when they needed it.

He worked at the same company for nearly 30 years and was a valued and highly skilled member of the small team. His friends at work knew him as 'Wack' which later came out as being due to him smoking 'roll ups'! He was well liked and respected by his peers and friends.

Justice for his sacrifice is impossible to quantify. Nevertheless, he most certainly deserves recognition for his efforts to provide continuous support and a safe refuge whenever he could. It is heartbreaking to think that, ultimately, had the professionals properly addressed the underlying issues, Charles and his immediate family could have lived with stability and security. Had these then been considered the norm - rather than the chaotic existence that did persist - Charles would, in all probability, still be with us. This leaves a sense of betrayal throughout the family.

As laughter was an important part of our lives with Charles we would like to conclude on a lighter note. Fortunately, we all shared a similar sense of humour. This is just as well as we would often find amusement within serious situations! Hilarity always punctuated our family gatherings - happy or sad

- wherever they may have been, helping us to deal with those dark, difficult moments. Unsurprisingly, we often still chuckle together although it now comes with added poignancy. That notwithstanding, we often sense Charles laughing with us or, perhaps more frequently these days, at us!!

So, we will seize the opportunity for revenge by divulging Charles' disgust at receiving a most unusual gift in the form of a giant gnome! The rest of us chortled as he beheld, with a look of horror, this apparition before him! Although he dutifully took said gnome home, he was already making plans to be rid of it! The gnome's demise came some months later - being 'accidentally' run over whilst in the process of being moved to an alternative location. In certain quarters, its existence has never been forgotten and doubtless, this poor, innocent gnome will provide the family with a jolly good laugh for many a year!

Charles loved music and going to gigs - seeing Green Day was always top of his list. With a little artistic license, using some of the tracks from albums in Charles' record collection, we have created a rather cryptic, family tribute:

Charles was a true 'travellin man', a bit of a 'speed king' particularly when on 'holiday' in 'America'. He was no 'American idiot' though, more a 'free bird' - hardly an 'Albatross' definitely not a 'songbird'!!

When Charles wasn't saying 'I'm in love with my car' he was telling Debbie 'you're my best friend', the 'love of my life' - we share 'a kind of magic' and 'I'm always touched by your presence dear'. 'Come with me', 'there's a place for us', he'd say, let's climb that 'stairway to heaven' …..

Charles, you were always 'good company' and we desperately still 'wish you were here'. 'Heroes are hard to finding' but you are ours - not least because you would say 'have a drink on me'.!! We all owe you a huge 'Thank you'. We 'don't stop believing' that you will soon be 'homeward bound' to be with us again. In our 'dreams' on a 'black night', looking up at the stars, we know you are enjoying 'the great gig in the sky' and will continue to 'shine on you crazy diamond'.

There is an unspoken but innate understanding between siblings, now extending to Debbie, in which, despite not living in each other's pockets, we know that in times of need the others will do whatever they can to help. It is a belief without expectation. Just an inherent special bond that unites us. This allows us to live safe in the knowledge that each individual will do their best at any given time - which on occasion, may indeed be nothing; that is ok too.

Thus, how desperately it hurts that we could not be there when Charles needed us most. Nevertheless, how blessed are we all to have had Charles in our lives - his memory sustains us. As does the ongoing support we continue to give each other, sharing the load when, as often happens, it threatens to weigh us down.

Emotions are still raw and it is hard to comprehend that Charles cannot return to us. However, if we can spare other families from suffering such a traumatic, heartrending experience that may bring some small comfort to the family as we go forward. Such a caring, modest, unassuming and (referencing Lynyrd Skynyrd) 'simple man' should be remembered for all his good deeds - carried out quietly, without fuss; Charles loathed being centre of attention yet his manner was inspirational - many could learn much from him.

All of those who knew him are shocked to have lost such a loved man and they miss him.

Preface

Safer Somerset Partnership, panel members and the authors wish at the outset to express their deepest sympathy to Charles's family. This review has been undertaken in order that lessons can be learnt; we appreciate the engagement from his family and friends throughout this difficult process. The chairs of the review aimed to work with those who knew him sensitively and with compassion.

This review has been undertaken in an open and constructive manner with all the agencies and all engaged positively. This has ensured that consideration of the circumstances has been carried out in a meaningful way and address with candour the issues that it has raised. The review and every panel meeting have been conducted with an open mind and aims to avoid any hindsight bias.

1. Introduction

1.1 Charles was killed by Peter (Charles's stepdaughter's ex-partner) and Craig (Peter's friend – he has not been included within this review) in May 2022, also involved and at the scene was Becky (Charles's stepdaughter). Due to Charles and Becky being family members Safer Somerset Partnership (SSP) identified the case met the criteria for a Domestic Homicide Review (DHR).

1.2 This DHR is a statutory requirement and it examined agency contact and/or involvement with Charles, Peter, and Becky, their responses, interventions and support provided. All of those involved were residents in Somerset prior to Charles' death. The report will highlight positive and supportive practice along with missed opportunities and/or any barriers in accessing services and any learning that can be shared to reduce the risk of such a tragedy in the future.

2. Timescales

2.1 In 11/08/2022 Safer Somerset Partnership received a Domestic Homicide Review referral regarding the death of Charles from Victim Support. The decision to carry out the review was made in 2/10/2022. In November 2022 independent chairs were commissioned with the aim of completing the review within the six months statutory timeframe.

2.2 The Home Office Multi-Agency Statutory Guidance for Domestic Homicide Reviews[33], (paragraph 46) states that the target timescale for completion of the review of six months. Initial information was sought by Safer Somerset to ensure different agencies were aware of the DHR and the requirements as well as the introductory panel meeting. However, the review was unable to be completed in six months due to the on-going criminal case which concluded in February 2023 as well as additional information required by the panel. This caused a delay in any contact with Charles' family, Becky, and Peter. This delay was approved by Safer Somerset Partnership and the panel meetings were held in December 2022, February 2023, June 2023, and September 2023.

3. Confidentiality

3.1 In line with the Statutory Guidance (paragraph 75), to protect the identity of the victim, perpetrator, relevant family members and others and to comply with the Data Protection Act 1998 pseudonyms have been used which were chosen by Charles' family.

[33] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

3.2 The sharing of information between agencies in relation to this review was underpinned by the Information Sharing Protocol which is in place to facilitate the exchange of personal information to comply with the requirements of Section 9 of the Domestic Violence, Crime and Victims Act 2004[34] to establish and coordinate a DHR.

3.3 Panel meetings were all confidential and any sharing of information to third parties was carried out with the agreement of the responsible agency's representative, the panel and chair. The findings were restricted to authors of the reports, their managers and panel members. Once agreed by the SSP Board, the review will be presented to the Home Office for final approval. Any initial learning identified has been acted on immediately.

3.4 Charles was 56 years old and white British. Peter was 35 years old, and Becky was 32 years old, both are white British.

4. Methodology

4.1 Domestic Homicide Reviews became statutory on 13/04/2011 under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:
a) A person to whom 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; held with a view to identifying the lessons to be learnt from the death.

4.2 Agencies were identified to provide IMRs after SSP completed a scoping exercise with statutory and non-statutory agencies across Somerset. Each agency was provided with the terms of reference and asked to review their involvement with Charles, Peter and/or Becky including interviewing any staff where appropriate. All were asked to highlight positive practice, any learning, recommendations and actions.

4.3 All IMRs were quality assured and any recommendations and learning agreed by senior members of staff within each organisation.

4.4 In addition to IMRs the chairs were also provided with invaluable family and friends insight into Charles' background and his relationship with Peter and Becky.

4.5 Various pieces of research have been used within the analysis and are referenced throughout the report.

5. Involvement of family and friends

5.1 The chairs met with Debbie and the advocate at her home address and continued to remain in contact throughout the process. Charles's siblings were also supported by Victim Support and involved in the review.

5.2 A letter explaining the DHR was given to Becky by social services providing her with the opportunity to speak with the chairs, unfortunately this did not occur. Due to the significant amount of information with the report involving Becky social services sought permission from Becky and encouraged her to engage with the review. Although the chairs have not spoken

[34] https://www.legislation.gov.uk/ukpga/2004/28/contents

with her the panel have been reassured, she is aware fully of the review and the process involved.

5.3 Charles' employer was able to provide an insight into who he was as a colleague and friend. Emails were also sent to Charles' next-door neighbours offering to speak with the chairs.

5.4 The chairs met with Peter in prison with his probation officer in in April 2023.

6. Contributors to the review

6.1 IMRs were all authored by independent staff within each organisation who were not directly involved with any person discussed within the review. Those who were provided and presented an IMR to the panel were:

Agency	Representative	Information provided on
The You Trust (current SIDAS provider)	James Dore	Becky and Peter
Children Social Care	Sussanah Heywood	Charles, Debbie, Becky, Peter
NHS Somerset ICB (on behalf of Primary Care)	Emma Read	Charles
Avon and Somerset Police (IMR author)	Nigel Colston	Charles, Debbie, Becky, Peter
Somerset Drug and Alcohol Service	Jane Harvey-Hill	Becky and eldest child

6.2 The panel comprised of statutory agencies recommended within the statutory guidance and specialist services of male victims and domestic abuse. The review panel consisted of:

Agency	Representative and role
Bielec Consultancy Ltd	Katie Bielec
Clare Walker Consulting Ltd	Clare Walker
SCC Public Health (SSP)	Suzanne Harris - Senior Commissioning Officer
The You Trust (current SIDAS provider)	James Dore - Strategic Manager
Children Social Care	Cathy Jones - Head of Service Children Looked After & Leaving Care (Acting)
NHS Somerset ICB (on behalf of Primary Care)	Emma Read – Safeguarding Lead
Avon and Somerset Police	Sam Williams – Detective Chief Inspector
Somerset Drug and Alcohol Service	Jane Harvey-Hill - Safeguarding Manager

7. Authors of the Overview Report

7.1 Katie and Clare are both independent domestic abuse consultants, they have completed the Home Office Domestic Homicide Review training, are accredited DHR chair's with AAFDA[35] and members of the AAFDA DHR Network. Katie is also an accredited Chair for SILP[36].

7.2 Katie chairs MARAC, chaired MARMMs[37] and stalking clinics. She is an associate trainer for Safelives, Rockpool, The Hampton Trust. Clare is an Expert Witness, and a trainer coercive control, parental alienation, family court, child to parent violence. She is a co-creator of the VOICE Programme (Victims Of Intimate Coercive Experiences).

[35] https://aafda.org.uk/
[36] https://www.reviewconsulting.co.uk/silp-reviews/
[37] Multi Agency Risk Management Meetings

7.3 Clare is not associated to any agency who have provided information for the review, Katie worked for the You Trust between 2010 and 2021. Although the You Trust are panel members, were the provider of the domestic abuse service within Somerset (SIDAS) at the time of Charle's death and was involved with Becky, Katie was the manager in Dorset and was not connected with this project during this time. Since leaving The You Trust there has been no connection with the service or Katie's consultancy.

7.4 Clare and Katie have no personal or professional involvement with Charles, his family, or friends.

8. Parallel Reviews

8.1 In November 2022 Peter and Craig pleaded guilty to manslaughter and were sentenced to 7 years imprisonment. In February 2023 Becky was found guilty and convicted of battery with a suspended sentence and a 5-year restraining order protecting Debbie.

8.2 The Coroner has permanently suspended the inquest into the death of Charles based on the criminal conviction of a third party for a homicide offence in relation to his death[38]. As such, there was no inquest and no outcome to report.

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

9. Equality and Diversity

9.1 The chair and panel members considered whether any protected characteristics[6] were relevant to the review.

9.2 At the time of Charles' death, Charles was 56 years old, Peter was 35 years old, and Becky was 32 years old. All were identified to be white British. There was no information to suggest Charles or Peter had a disability.

9.3 Becky told services that she had Multiple Sclerosis (MS) or ME[39], the review has been unable to confirm this, whether it was recorded as a disability or if she required any additional support, even so it has been taken into consideration whether this impacted the services she received.

9.4 Mankind[40] states that ONS 2023 data shows men are more likely to be subjected to domestic abuse between 20 – 24 years old with the number of victims reducing significantly after 40 years old. This is not to say it does not happen and it is essential when exploring familial abuse age is explored to understand the risks those who are older face from family members.

9.5 No religious beliefs were disclosed for anyone involved.

9.6 Charles sex was taken into consideration for this DHR as a risk factor due to domestic abuse and domestic homicides of men being significantly fewer than female victims. The panel felt it important to understand if Charles faced barriers in identifying the abuse and seeking support as well as agency responses to him and others involved in the review.

[38] Schedule 1 of the Coroners and Justice Act 1996
[39] https://www.nhs.uk/conditions/chronic-fatigue-syndrome-cfs/
[40] https://mankind.org.uk/statistics/statistics-on-male-victims-of-domestic-abuse/

10. Dissemination

10.1 Charles' family and all agencies involved in the review are aware the Overview Report and Executive Summary will be published once agreed by the Home Office; however, the action plan has already been disseminated with all relevant agencies to ensure immediate action and learning can be taken forward. All other reports and IMRs will remain confidential and will not be shared.

10.2 The final Overview Report and an Executive Summary will be published on the SSP website[41] and shared with the family, Safer Somerset Partnership Board, Avon and Somerset Police Crime Commissioner and the Domestic Abuse Commissioner once agreed by the Home Office.

10.3 SSP and the chairs will work with the family and other partners with regards to any public/press interest, the reports will be available on the Somerset Council website.

11. Homicide the facts

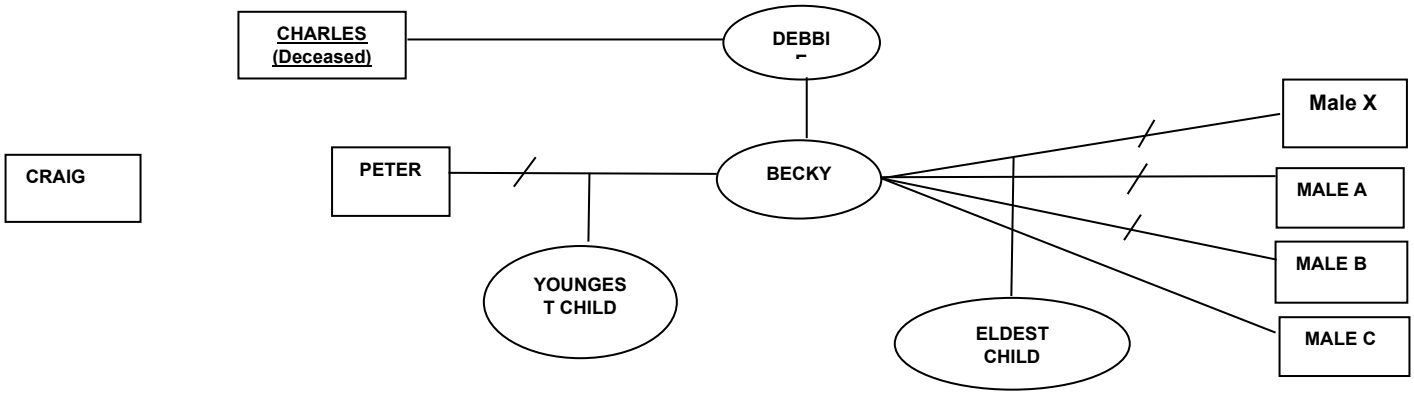
11.1 On the night of Charles' death Becky found messages on her eldest child (aged 12 at the time) phone from Charles. She became concerned about the content of these messages, one of which called the child "*hot stuff*". This resulted in Becky sending the messages to Peter, her ex-partner.

11.2 Peter and Craig drove from where they lived, approximately 1 hour drive away and attended Becky's address after receiving the messages, both had been drinking prior to their arrival. Peter called Charles on the home landline on 3 occasions. At first Charles was in the shower and unable to speak to Peter, on the final call, Charles told Peter he would need to get dressed to come to the flat.

11.3 Peter, Becky, and Craig then attended Charles and Debbie's home address (this was in the same town as Becky), whilst Charles was getting dressed. Debbie answered the door to Peter who told her he wanted to speak to Charles. When Charles came to the door Peter and Craig repeatedly punched him. As a result of the attack Charles quickly fell to the floor unconscious; he was taken to hospital where he subsequently died from his injuries.

11.4 Police carried out further investigations with regards to the messages sent by Charles, and no improper or criminal activity was found.

12. Genogram



[41] https://somersetdomesticabuse.org.uk/domestic-homicide-reviews/

	Relationship
Charles	Long term partner with Debbie, Stepfather to Becky, Step-grandfather to Becky's children
Debbie	Charles long term partner, Becky's mother, and Grandmother to Becky's children
Becky	Debbie's daughter, Charles's stepdaughter, Peter's ex-girlfriend, mother to 2 children
Peter	Becky's ex-partner, father to Becky's youngest child
Eldest Child	Child of Becky and Male X
Youngest Child	Child of Becky and Peter
Male X	Father to Becky's eldest child (he is not involved within this review)
Male A	Becky's ex-partner (during 2020)
Male B	Becky's ex-partner (during 2021 – 22)
Male C	Becky's partner at the time of Charles death (during 2022)
Craig	Peters' friend and was found guilty of the manslaughter of Charles

13. Family and relationship background

13.1 Charles was born in Dorset and moved to Somerset when he was 2 years old. His parents were landlords of several public houses, he went to a local school and never ventured far, settling down with Debbie in the same town he grew up in.

13.2 Charles has 2 siblings and 3 step siblings all of whom were close even though they all live across the country.

13.3 Charles and Debbie were partners for 17 years; they were never legally married however they lived together for many years.

13.4 Debbie has 3 children all adults, none lived with her at the time of Charles death. Debbie's relationship with her daughter was fractured, even so Debbie and Charles provided support to Becky's two children.

13.5 Becky's youngest child is with Peter's however, Peter considered Becky's eldest child as his own. Becky and Peter had been in an on/off relationship for 9 years. At the time of Charles' death, Peter was living with a new partner and Becky was in a new relationship, neither of the new partners were linked with Charles' death in any way.

14. Chronology

14.1 The panel and authors identified this review as complex due to the dynamics of the relationships, therefore as much information on all those involved was gathered. The panel have made all attempts to ensure the review was proportionate however, it is noted there is extensive information and analysis on Becky due to there being very little information on Charles or Peter.

14.2 The following information has been provided by agencies which was outside the scoping dates but relevant to the report due to the consistent prevalence of domestic abuse:

14.2.1 Becky has been known to services due to domestic abuse, substance misuse and mental health since 2010.

14.2.2 When Becky was pregnant with her eldest child in 2010, the unborn child was placed on a child protection plan due to the risk of significant physical and emotional harm from domestic abuse (not Peter). In 2011 due to the continued risk of domestic abuse, Becky and her child

moved to a refuge for 18 months. Care proceeding concluded at the end of 2011, Becky was granted a Residency Order and children social care involvement ceased in April 2012.

14.2.3 Avon and Somerset Police were involved with Peter and Becky on fourteen separate occasions between May 2012 and September 2016 (the children were known or assumed to have been present at most of these events).

14.2.4 In 2014 Peter was convicted at North Somerset Magistrates Court and sentenced for assaults against Becky. He received a Community Order, required to complete Building Better Relationships[42], Supervision for 2 years and unpaid work supervised by the National Probation Office.

14.3 Information within the terms of reference scoping dates (May 2020 – May 2022):

14.3.1 In mid-May 2020, an urgent strategy meeting was held with regards to the children returning to the care of Becky, who had resumed her relationship with Peter. All partners agreed the Section 47 of the Children's Act 1989[43], the threshold had not been met and no assessment was completed.

14.3.2 During late July 2020 Becky called Police stating that Peter had "dragged her out of his address" and had "been physical" with her, she had visible bruising to her right arm and around her throat, Peter was arrested, the children were not present at the time of the incident (this occurred in North Somerset). A DASH RIC was completed which was graded as high risk, a 12-month STORM[44] maker added to Becky's phone, she was taken to temporarily stay with her father, a referral was made to NextLink (IDVA Service), MARAC, Children Social Care and Education. She was also provided with advice regarding the HollieGuard App and contacting her GP.

14.3.3 Peter was subsequently released on pre-charge conditional bail, with conditions not to contact Becky nor to attend any location where she might reasonably be.

14.3.4 In mid-August 2020 Becky was heard at North Somerset MARAC with Peter as the named perpetrator. Present at the meeting were Police, Next Link, Children Services, Children Centre, Education, Adult Social Care, Hospital, Mental Health, Health Visitor (Sirona Care and Health), NPS and CRC (Probation), 'We are With You' (Drug and Alcohol Services) and Housing. Information shared at the MARAC:

- **Police** – *Police were met by Becky who was in the stairwell of Peter's flat, she was in shorts and a t-shirt and had visible bruising on her arm and throat. She stated Peter had caused the injuries by grabbing and dragging her from the lounge/bedroom and into the hallway. He had called his younger brother from the flat above who had assisted in evicting Becky from the flat. Becky stated they had consumed a 75cl bottle of vodka together, she was emotional stating she and Peter had separated 3 to 4 weeks previously but were still sleeping in the same bed. Due to her intoxication a statement was not taken.*
- **NextLink** – U*nable to contact and closed.*
- Children Services – *Open for assessment, the family were with a friend and* Becky *was not planning to return to the relationship.*

[42] https://www.gov.uk/government/publications/evaluating-the-building-better-relationships-programme-feasibility-study-for-an-impact-evaluation-of-proven-reoffending
[43] https://www.legislation.gov.uk/ukpga/1989/41/section/47
[44] Treat as urgent marker

- **Adult Social Care** - *September 2016* Becky *had been headbutted by Peter but stated he had left the property and she was aware of support services. Agreed to close, she was asked if she required support regarding her MS, but she declined.*
- **Health Visitor** – *The children had moved school and nursery;* Becky *had told her health visitor she suffered depression and ME.*
- **NPS (Probation)** – *Peter was previously known for Actual Bodily Harm (ABH) against* Becky *in 2014, requirements to complete BBR – nothing current.*
- No information was shared or held by other services.

14.3.5 Actions from the MARAC:

- MARAC to MARAC transfer to Somerset.
- The social worker to encourage and support Becky to engage with domestic abuse support services in Taunton, Somerset.

14.3.6 At the beginning of September 2020, the social worker referred Becky to SIDAS indicating she and her 2 children were living with Debbie and Charles. Within the referral it highlighted physical and emotional abuse, that the couple had separated, and that Becky was clear she did not want to resume the relationship. They raised concerns that both had stated they loved each other and, given their history of reconciliation there was a risk this could happen again. They also highlighted that Becky was vulnerable to further abusive relationships.

14.3.7 The DASH within the referral to SIDAS scored 7, however SIDAS escalated the referral to an IDVA due to the non-fatal strangulation incident in July 2020. Even though allocated to an IDVA it was not referred to MARAC and no MARAC-to-MARAC transfer was completed.

14.3.8 The day after this conversation Becky met with the IDVA face to face, a DASH was completed where she scored 13 (medium risk). Becky disclosed Peter had been sending her messages daily and he was currently being nice. She was advised to call 101 and speak with the OIC with regards to the breach of bail, however, Becky stated Peter had told her the messages had been removed. The IDVA made attempts to confirm this, but the OIC was not on duty and a message was left. The IDVA discussed refuge, but this was declined, target hardening was offered for Debbie's property, but this was refused.

14.3.9 During the meeting Becky informed the IDVA she had an appointment with her GP the following week to discuss her mental health, depression, and her diagnosis of relapsing MS. She was also in the process of applying for housing and a homelessness application had been submitted to Southwest and Taunton Housing options. She also updated the IDVA that her social worker was completing a Children and Families Assessment and was seeking to transfer the case to Somerset Children Social Care.

14.3.10 The IDVA notified Becky she was going on annual leave from the end of September for 2 weeks and gave the SIDAS helpline number and explained she could call if she required support during this time. No future appointments were made with the IDVA. The IDVA updated the social worker of Becky's housing situation, she also made attempts to contact Becky's housing officer via email regarding Charles' decision to ask Becky to leave.

14.3.11 The nation went into a second COVID lockdown on 31/10/2020 ending 14/11/2020.

14.3.12 Children social care received a referral from the hospital after Becky had presented stating she had taken an overdose in front of the children the previous night. She also disclosed she had punched her mother and headbutted her stepfather, it is unclear if the children witnessed the assault (no allegations of this nature were made by Charles or Debbie). The children

remained with the maternal grandparents. Becky was discharged from hospital and was assessed by the mental health team with actions for the Home Treatment team to follow up with calls, there was also a referral to the psychiatric liaison team (the review has been unable to determine any action taken regarding Becky's mental or physical health).

14.3.13 At the beginning of September 2021 Becky was allocated a substance misuse (SDAS) and mental health worker who were part of the FSG. Domestic abuse had not been identified as a risk or need for support, so no domestic abuse worker was allocated.

14.3.14 Within a week of allocation, the substance misuse worker arranged to meet Becky. At the assessment Becky stated she was not keen on stopping her use of cannabis or alcohol but would consider reducing and gaining control of her usage. She disclosed she took a large amount of pain killers and was struggling with her mental health due to her past. She did not disclose any further information regarding this; however, she told the worker she was "*mentally fucked up in the head*" and explained how she had sent her mum a video of her cutting her arms and taking an overdose. She felt no mental health professional was supporting her and she was waiting for the mental health worker to make contact. Becky added she had MS and asthma, she also disclosed she was 'sleeping with 2 different men' and called herself a '*slut*' (no details were taken of the men). A further appointment was made the following week; however, this was cancelled by Becky due to her feeling unwell.

14.3.15 At the beginning of October 2021 Becky attended hospital with abdominal pain reporting she had been hit by a car 10 days earlier, the hospital was concerned regarding the level of bruising over her body and referred her to children social care.

14.3.16 During a FSG group supervision in mid-October concerns were raised that Becky may be in a domestic abusive relationship with Male A. Becky had disclosed to the social worker that Male A was controlling, she attributed bruising on her body to rough sex (this has been recorded as consensual) and told them she was "*nothing*". She informed them the relationship had ended but had now resumed and she would be putting in some boundaries (it is unclear if this was the ex-partner who had been harassing her in June 2021). An action from the supervision was given for the social worker to explore domestic abuse with Becky. A DASH was not completed, and it is unclear what safety work was carried out and whether the domestic abuse was discussed further.

14.3.17 A home visit was completed by the substance misuse worker where Becky reported she was not doing well, was smoking cannabis, and drinking daily and the children were with her mum for as long as she needed them to be there. She told the worker it would have been better if she killed herself and knew what she would need to do should she need to. She disclosed she and her mum had received threats from an ex-partner – Male B (not Peter or Male A). She stated he had not been violent but was controlling. Her mum had identified these behaviours, raised it with Becky and this is why she had ended the relationship. Becky was provided with a lock box for the cannabis and helpline numbers. The substance misuse worker informed Becky that she would update the social worker and mental health worker (this was completed via email). No DASH was completed, no discussion of domestic abuse support or report to Police.

14.3.18 A further CiN meeting was held in mid-November 2021 with a focus on Becky's alcohol consumption, her feeling low and depressed, which was causing her physical pain (there was no medical evidence for this pain). Domestic abuse was not raised or discussed at any stage within this meeting even though there had been 2 disclosures and 2 different perpetrators.

14.3.19 A further CiN meeting was held, Becky disclosed she had cut her wrists over the weekend whilst the children were with Peter.

14.3.20 Charles contacted children social care and raised concerns that the eldest child had bruising to her upper arms, she had disclosed that Becky had done this when she was drunk and as a result the children stayed with Debbie and Charles for several weeks.

14.3.21 In mid-December 2021, a strategy discussion was held in response to concerns regarding Becky's mental health, her use of alcohol and substances and the impact this was having on her care for the children. There were also concerns regarding a male who was found at Becky's home (no details were available for the review of who this person was, what possible risks he posed or their relationship status). Charles and Debbie offered to care for the children, but Becky declined this offer. Charles and Debbie were assessed for potential carers for the children, and it was agreed for a Section 47 to be completed. A Child Protection Conference was held, Becky, Peter and Charles were all present and the children were placed on a Child Protection Plan in January 2022 under the category of neglect.

14.3.22 SDAS continued to support Becky and her eldest child throughout March and April. During her sessions Becky disclosed she had used alcohol from an early age, that her relationship with Male C was good, they were getting on well, he was getting on with the children and he was supporting with parenting. The eldest child was being supported in how to manage her anger and how this affected others. She also spent time with her father and his family which she really enjoyed (it is unclear if this was her biological father or Peter).

14.3.23 At the end of March, a further Child Protection Conference was held which Becky, Peter and Charles attended, it was agreed the children would remain on the plan under the category of neglect. The social worker had completed one session of healthy relationships, but no detail was provided.

14.3.24 Charles was killed by Peter and Craig in mid-May.

15. Analysis

15.1 For full analysis please see the full report, the panel felt for this summary it was important to include a section of the analysis regarding Jason, due to the notable information on both Peter and Becky.

15.2 Throughout this review the panel have tried to ensure the report is proportionate in the response to those involved, however, due to the extensive information on Becky the analysis has focused on identified key themes regarding her and the domestic abuse.

16. *Charles's role in Becky and the children's life*

16.1 Charles was loved greatly by Debbie, his family, the children, friends, and colleagues. He was also caring to Becky and the 2 children, was a supportive and prominent member of any meetings and action plans. He supported Becky when she was in abusive relationships, when her mental health deteriorated, or her alcohol intake increased especially when offering a place to stay and facilitate childcare or contact. Due to his role within the family, he provided stability for the children and a place of safety.

16.2 From discussions with family and with professionals who were involved with Charles it does not appear he was ever concerned for his own safety from Peter, Becky, or any other person. Even though he had been subjected to verbal and physical assaults by Becky he remained supportive of her throughout.

16.3 Charles was clearly aware of the domestic abuse and sought to support Becky and Peter in the raising of the children. From discussions with Debbie, Peter, and social care he was a fundamental member of the family supporting Becky and providing consistency when there was chaos and disruption. When there is domestic abuse within a family there are wide reaching implications not just to children but also wider family members. It would be beneficial for all of those involved with families to be aware of the 'ripple affect' from domestic abuse.

17. Learning

Learning Point 1
Becky has experienced ACEs and trauma throughout her entire life which has impacted on her mental health, her misuse of substances and her responses to her family and agencies. Agencies need to be able to understand trauma responses, how to provide trauma informed practices and how to support for successful and positive outcomes.

Learning Point 2
Judgements and decisions influenced by unconscious bias can result in decisions being made with inaccurate, misplaced, and incomplete evidence. Agencies need to understand the relevance of unconscious bias in their practices and decision-making, which would enable a less punitive response to victims and less collusive reaction to perpetrators.

Learning Point 3
There were multiple missed opportunities within the family safeguarding team to have explored Becky's relationships in further detail, risk assess, make referrals, offer support, and seek guidance from the domestic abuse workers. Failure to do this increased Becky's risk not only from her ex-partners but also herself due to the impact of the trauma experienced.

Learning Point 4
The family safeguarding team are reliant on domestic abuse workers to complete the DASH which creates a barrier when there is no domestic abuse worker involved with the family, this creates missed opportunities to appropriately risk assess and safeguard victims.

Learning 5
There is no advice or guidance within the North Somerset MARAC protocol regarding who takes responsibility to complete a MARAC-to-MARAC transfer when it is as an action from the meeting. It is essential that MARAC actions are SMART and identifies who will complete them.

Learning Point 6
Information sharing across borders and amongst agencies is key to be able to appropriately risk assess and offer support to those who are vulnerable. The MARAC was proactive in their action for the MARAC-to-MARAC transfer however, due to there being no 'check and balances' to ensure actions are completed this opportunity was lost. It is difficult to identify who the responsibility would lie with regarding quality assurance of cases as MARAC is not statutory.

Learning 7
Professional curiosity was not used to explore what Becky was experiencing, complete any risk assessments and review support.

Learning Point 8
Agencies are to consider discussing and requesting a DVDS when a vulnerable person is in a new relationship and there are concerns for their safety.

Learning Point 9
When completing the DASH RIC, practitioners are to be aware of high-risk factors and clusters to enhance their professional judgement when considering referrals and signposting.

Learning Point 10
Although contact and engagement with the IDVA was good this was inconsistent, with no further appointments scheduled or written explanation for these inconsistencies.

18. Recommendations

Recommendation 1
Safer Somerset Partnership to evaluate their training offer which includes:

- ACEs.
- Trauma Informed Practice.
- Unconscious bias.
- Domestic Abuse Disclosure Scheme.
- Counter Allegations.
- Professional Curiosity.

Recommendation 2
Where there is possible domestic abuse, FSG workers are to obtain consent from the non-abusive parent, discuss at group supervision and seek consultation with the specialist domestic abuse worker with regards to risk and intervention.

Recommendation 3
All family safeguarding practitioners when identifying domestic abuse through assessment should be confident and competent in completing the DASH in advance of forwarding to specialist domestic abuse support.

Recommendation 4
MARAC to have the same statutory framework as other conferences where vulnerable people's safety and wellbeing are discussed to ensure tighter and robust accountability for actions and sharing of information.

Recommendation 5
All agencies to ensure those completing the DASH understand any cases where there has been Non-Fatal Strangulation is a high-risk factor and is to be referred to MARAC with detail provided within the risk assessment.

Recommendation 6
SIDAS to have contact with clients weekly and future appointments to be offered to clients after each support session. These are to be evidenced on the case file with explanations provided if this is not achievable.

Recommendation 7
North Somerset MARAC Protocol, section 5.13 (MARAC to MARAC transfer) to be amended and include: '*when an action has been identified within the meeting for a MARAC to MARAC transfer the lead professional for this is the MARAC coordinator and this is to be completed within 48 hours of the meeting*'.

19. Conclusion

19.1 There is no evidence to show that Charles had any direct involvement regarding the domestic abuse, other than offering support and a home to his partner, Becky, his grandchildren, as well as being supportive with the contact of the children and Peter.

19.2 Charles was a hardworking man who was loved by his friends and family, and he lost his life by those he knew and trusted. As demonstrated within this report Charles had never come to any attention of the authorities and was healthy (apart from experiencing COPD) and therefore there has been very little information regarding him for the panel to analyse.

19.3 However, due to the personal connection between Charles, Peter, and Becky we have had the opportunity to be able to explore the interactions of agencies with Peter and Becky in a hope we can support good practice and missed opportunities. It has been a difficult DHR to complete as we wanted to ensure Charles was not lost in any of the report and are conscious the focus is on Becky and Peter. There have been repeated missed opportunities that have impacted this family and cannot be overlooked.

19.4 This family had come to attention with the Police and Childrens Social Care for over a decade and although there have been changes to practice, policy and legislation over this period the panel have been able to identify areas of improvement outside of these aspects:

- The absence of professional curiosity,
- Effective information sharing including across borders,
- Lack of understanding of domestic abuse and the complexities for those subjected to it,
- Fragmented interventions as well as collusion with Peter in accepting him as protective factor for the children, whilst Becky was not,
- Proportioning the blame on the abused Mother rather than focusing on the causal factors,
- Lack of the DASH RIC being completed after disclosures.

19.5 However, there were proactive measures put in place:

- Police arresting Peter, obtaining a successful conviction, and seeking evidence led prosecution,
- Police continuously treating Becky as the victim,
- The children's safety identified as being at risk,
- IDVA's review of DASH and support plans.

19.6 Many of the key learning points identified in this review have already been recognised in other reviews across the county, the Domestic Homicide Review – Learning from Somerset's Cases (2017), noted 'the need for developments in practice regarding domestic abuse cases where Toxic Trio (now known as Trio of Vulnerabilities) is present'.

19.7 Other areas noted were to improve practice, information sharing, cross border information processes across agencies, application of DASH RIC, agencies not working in silo, professionals lack of knowledge and understanding of the nuances of domestic abuse especially where violent resistance is present, meaningful referrals to specialist agencies, application of

professional curiosity. All of these have been identified within this review, so the question we now must ask is: If these are reoccurring, how are we effectively making change? Somerset have developed a Domestic Abuse Strategy and have a board which aims to learn and make changes. Although some may be instant others are systemic and a cultural shift which will take time to ensure it is done correctly and only once. To ensure learning and change happens across the entire workforce DHR's are to be shared in workshops and learning events to avoid these tragedies from happening again.

19.8 We as a panel cannot imagine the pain and the hole this devastating tragedy has created for those who have lost their husband, brother, grandfather, son, friend, and colleague. Domestic abuse, domestic homicide and domestic suicide has far-reaching impacts not only effecting immediate family but also, extended family, and communities. This is why it is imperative that agencies apply the valuable learnings sought through this domestic homicide process and involve frontline workers, strategic partners and most importantly the communities, in their drive to make a difference.

Statement from the family

The family would like to begin by expressing gratitude to all those involved in this review, for their time and effort in gathering the required information and to the chairs for producing this report. Our appreciation goes to them for their support, kindness, encouragement and understanding. The part they played in getting us this far should not be underestimated.

It has been rather a long roller coaster ride which has taken a huge toll upon us all. However, having the opportunity to have a voice, and to finally be able to speak up for Charles, brings some validation.

Since Charles' life was taken, the family has endured endless anguish. Throughout the various court hearings, we endeavoured to maintain our dignity and composure - an extraordinarily difficult challenge given that we heard harrowing evidence and, at times, insulting statements - most notably from the defence teams. Thus, we listened to Charles' name being sullied whilst being denied any chance to protect his good character - relying on others to do so, or not…..

The family have largely felt ignored since the incident. Although, to be fair, we have no issues with the investigation itself and encountered some true gems along the way - the amazing people at Victim Support, brilliant counsellors and DC McFall from Avon and Somerset constabulary - without whom we would have sunk without a trace. The 'justice' system rarely seems to accommodate the victims or their families. However, providing feedback, relating to various departments, did result in a positive meeting with the DCI involved in the investigation.

Our desire to gain some vindication for Charles was bolstered by thoughts of him. The loss of this cherished family member, the constant heartache, giving us the incentive to press on. We hope Charles would be as proud of us as we are of him. We therefore now wish to reclaim the real Charles and not let his name be defined by the brutality that ended his life; rather we desire to remember the way he lived, loved, and laughed.

As with our experiences during the legal process, even basic communication can make such a difference. The added distress caused by lack of contact leaves families feeling isolated, neglected, and invisible. Whereas often just a brief response can alleviate those negative emotions. This report indicates that better communication between the services/agencies would have resulted in a more positive outcome for Becky, her children and, therefore, all the family.

Whilst we recognise that most of the good work carried out by these vital, valuable services goes under the radar and we understand that workload, budgets etc can impact on proficiency, we implore those responsible for providing them to heed the recommendations contained herein.

How do professionals NOT truly realise the ongoing effect that so many missed opportunities have on families in such circumstances? Our lives are affected daily whereby simple tasks become mountains to climb. With so much mental and emotional overload, exhaustion permeates everything. Any planning is impossible, normal thought processes non-existent - indeed the composition of this statement has been all consuming (albeit sporadic due to bouts of overwhelming fatigue) over a period of 7-8 weeks; much energy has been invested as it is important to the family to grasp the opportunity to make this contribution. There have been many areas to consider and our desire to convey our thoughts has not been aided by frequent lapses in clarity and concentration.

The extra pressure placed on our immediate families is a greater burden because, whereas previously helping them, we are rendered ineffective and in desperate need of their assistance. For the siblings, interaction with their children and grandchildren is much diminished, therefore many of us are missing out on precious moments to make new memories.

Yet for Debbie it is far worse - very little contact with her grandchildren, few updates, and no opportunity for any meaningful conversation with them. Albeit we appreciate the gravity of their situation and duly recognise that careful handling is required, it seems they are all being punished through no fault of their own.

Our inability to function means we are unable to work efficiently thus employers and colleagues are affected. For instance, Debbie has been signed off, due to anxiety, for 8 weeks with the possibility that she will not feel able to return to her current role. A job she loves, excels at, and where she is valued. Her employers have been exceedingly supportive throughout this ordeal. What a travesty.

Another example of consistently being overwhelmed and distracted is ongoing struggles to cope with paperwork causing missed payments which have, on occasion, resulted in fines. Friends are neglected, telephone calls and messages ignored, any necessary gatherings taking a toll - requiring longer recovery periods. Our wish is to see improvements within the relevant services/agencies in order that other families will not have to suffer in this way.

Bearing in mind Charles' actions and intentions regarding the grandchildren, we have serious concerns for their welfare and are anxious that they should be provided with all the appropriate support necessary through the coming years. Due to their vulnerability, the possibility that their circumstances could result in another generation allowing themselves to become involved in similarly abusive relationships is a terrifying prospect.

Becky too, despite her involvement in the death of Charles, requires the assistance denied to her for so long. We hope that those supporting Becky will remind her that she has been let down by biased attitudes and neglect of dutiful care whilst emphasising that help is available to her. After all, if she can overcome at least some of her problems, that will be to the benefit of all concerned - not least her precious children.

Reassurances are required confirming that attitudes and working practices will change, that recommended training procedures will be adhered to. Otherwise, we fear that this could just serve to highlight the futility of Charles' efforts to assist in improving the children's quality of life, making those violent actions even more devastating. Will those on the ground be allowed time to address issues

within families as they arise, not be constrained - by pressure from above - on workload, time, finances etc Surely early intervention cannot only save much heartache but money too.

We wholeheartedly agree with the Chairs conclusions regarding Peter in that he hoodwinks professionals, is manipulative, seeks to blame others and shows no remorse - we have, ourselves, witnessed a similar display by Peter.

The words uttered by the Judge in her summing up at Becky's trial declaring, when finding Becky not guilty of Public Order Offence, "Debbie gave as good as she got'" …. Well, the family agreed, good on Debbie - faced by two thugs attacking her beloved fiancé, Becky shouting and screaming, how could Debbie know what would happen next? Who of us can imagine what Debbie was feeling! FEAR?? Desperation to protect Charles …….

Having felt largely invisible throughout court proceedings, the Judge's acknowledgement (in her summing up) of the family's dignified behaviour made the effort of exercising much restraint worthwhile, another example of the positive impact of small, thoughtful deeds.
Sweet 'dreams' 'dearly beloved' Charles, we 'miss you' and whilst believing that 'love conquers all', we truly wish we could indeed 'wake you up when September ends' …….

Poem chosen by the family

Goodnight to you dear Charles
May the long time sun
Shine upon you
All love surround you
And the pure light
Within you
Guide your way on
May the winds of love blow softly
And whisper for you to hear
That we will love and remember you
And forever keep you near
As here in this final act
In sorrow but without fear
Held in our hearts so dear
May you travel onwards in gentleness and joy
To find your peace
Deep peace to you
Deep, deep peace…..

Courtesy of Helen Salway-Roberts (celebrant)

APPENDIX 1

Terms of reference

The review will:

- Consider the period from 01/05/2020 to Charle's death, subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events that are relevant, and which should be included.
- 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 criminal justice proceedings in terms of timing and contact with the family.
- Aim to produce a report within six 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 whether familial abuse) 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 Charles or his family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
    - Against the Equality Act 2010[45] protected characteristics.
    - Regarding children and pregnancy and any potential impact this had ensuring the safeguarding of any children during the review.
    - Whole family approach
- 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 and amongst 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

[45] https://www.legislation.gov.uk/ukpga/2010/15/contents

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. This is to include consideration of the impact of COVID-19. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

Appendix A – Action Plan

Domestic Homicide Review ("Charles" ref 047) Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome
What is the over-arching recommendation?	**Should this recommendation be enacted at a local or regional level? (N.B national learning will be identified by the Home Office Quality Assurance Panel, however the review panel can suggest recommendations for national level)**	**How exactly is the relevant agency going to make this recommendation happen? What actions need to occur?**	**Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation?**	**Have there been key steps that have allowed the recommendation to be enacted? List the evidence for outcomes being achieved**	**When should this recommendation be completed by?**	**When is the recommendation actually completed? What does outcome look like? What is the overall change or improvement to be achieved by this recommendation?**
Recommendation 1 Safer Somerset Partnership to evaluate their training offer which includes: • ACEs. • Trauma Informed Practice.	Local	Somerset Council Public Health on behalf of Safer Somerset Partnership to review its online (level 1) domestic abuse learning modules to	Somerset Council Public Health on behalf of Safer Somerset Partnership	A recent training survey has been sent to partner agencies to identify training needs to frontline workers and managers. (This covers domestic abuse, trauma	31/03/2024	

• Unconscious bias. • Domestic Abuse Disclosure Scheme. • Counter Allegations. • Professional Curiosity.		ensure inclusion of these topics. 2. Somerset Council Public Health on behalf of Safer Somerset Partnership to review its online (level 2) training offer to ensure to include more in-depth inclusion of these topics as part of its rolling programme of training to professionals on domestic abuse awareness. This may include commissioning specialist external trainers where appropriate.		informed, mental health, drug, alcohol, ACEs)		

Recommendation 2 Where there is possible domestic abuse, FSG workers are to obtain consent from the non-abusive parent, discuss at group supervision and seek consultation with the specialist domestic abuse worker with regards to risk and intervention.	Local	FSG team managers to discuss at the team meetings and to consider it at group supervisions.	Children Social Care		1/10/2023	
Recommendation 3 All family safeguarding practitioners when identifying domestic abuse through assessment should be confident and competent in completing the DASH in advance of forwarding to specialist domestic abuse support.	Local	Seek assurance that all FSG workers have completed domestic abuse and DASH RIC training via: Training records Supervision Case Reviews Annual service reports	Children Social Care SIDAS SDAS Open Mental Health		01/10/2023	

Recommendation 4 MARAC to have the same statutory framework as other conferences where vulnerable people's safety and wellbeing are discussed to ensure tighter and robust accountability for actions and sharing of information.	National	Domestic Abuse Commissioners Office for England and Wales to campaign for MARAC to become statutory within the Domestic Abuse Act 2021 review.	DAC		31/3/2024	
Recommendation 5 All agencies to ensure those completing the DASH understand any cases where there has been Non-Fatal Strangulation is a high-risk factor and is to be referred to MARAC with detail provided within the risk assessment.	Local	The Domestic Abuse Board to ensure domestic abuse and DASH training includes NFS as a high-risk factor and expectations for referrals to MARAC. NFS and high-risk factors to be included in newsletters and awareness campaigns.	Domestic Abuse Board Domestic Abuse Board – Comms Group	The MARAC protocol includes advice regarding professional judgement with regards to NFS and referral. A current review of all training available via Safer Somerset Partnership is being reviewed and quality assured to ensure high risk factors are included.	31/3/2024 01/12/2023	

Recommendation 6 SIDAS to have contact with clients weekly and future appointments to be offered to clients after each support session. These are to be evidenced on the case file with explanations provided if this is not achievable.	Local	Ensure all Inducted staff are fully trained, refresher training continually offered, and managers evidence conversations at case management.	SIDAS	All staff are fully competent and enabled to comply with securing and recording dates timely. This will be continually monitored with annual quality assurance checks.	31/3/2024	Although a date has been set this will be an ongoing action.
Recommendation 7 North Somerset MARAC Protocol, section 5.13 (MARAC to MARAC transfer) to be amended and include: '*when an action has been identified within the meeting for a MARAC to MARAC transfer the lead professional for this is the MARAC coordinator and this is to be completed within 48 hours of the meeting'*.	Local	MARAC Protocol to be changed to include the recommended wording.	Nextlink (North Somerset MARAC)		31/3/2024	

Appendix B – Home Office QA Feedback Letter

Home Office

Interpersonal Abuse Unit
Marsham Street

London
SW1P 4DF

Tel: 020 7035 4848 2

www.homeoffice.gov.uk

Suzanne Harris
Senior Commissioning Officer (Interpersonal Violence)
Public Health (Community Safety)
Somerset County Council
County Hall
Taunton
TA1 4DY

29th May 2024

Dear Suzanne,

Thank you for submitting the Domestic Homicide Review (DHR) report (Charles) for Somerset Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 24th April 2024. I apologise for the delay in responding to you.

The QA Panel felt this was a sensitive report that uses evidence-based research and links to a previous DHR. The glossary of terms and genogram is also useful.

The panel also noted that the family involvement is a real strength of this review, and humanises Charles, as well as demonstrating the huge impact his death has had upon the family. Their opening and closing statements and poems are powerful. The review has handled what appears to be a complex situation sensitively and shows good understanding of abuse.

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:**

- Given that Becky (the victim's stepdaughter and the perpetrator's ex-partner) has not been involved in the review and is not a perpetrator of the homicide, there is a significant amount of information on her within the review,

and a large portion of the analysis is around her. Has permission been sought from Becky to use this level of information?

- There was a lack of multi-agency response across agencies (police, children's services and domestic abuse services) to domestic incidents. There were missed opportunities to undertake DASH risk assessments, importantly a failure to refer to MARAC.

- There is little understanding of the impact of domestic abuse on Becky's children, especially as they were subject to statutory child protection procedures.

- The equality and diversity section is currently very brief and only identifies sex as a protected characteristics specific to Charles within this review. It might have been helpful to include age as well.

- The role is missing for the police panel member and there is no statement of independence for panel members.

- There are some areas where anonymity is compromised. For example, 16.3.46 reveals the eldest child's sex, as does the family statement on page 33. The date of death is revealed at 5.1 in the Terms of Reference, and at 16.3.56.

- There are references to the murder of Charles, but this is not appropriate given that the perpetrators were convicted of manslaughter.

- A reference is needed for the Judith Herman quote at 17.3.6, as well as for Appendix 1. More specific references are also needed in places, for example, footnote 21 should link to the specific findings, not just the IAS website.

- Some terms in the analysis appear without an explanation, relying on a link in the footnote, for example trauma bonding at 17.5.1. This is not necessarily accessible for readers.

- 12.1 does not include a dissemination list.

- The genogram might be more helpful earlier on, such as before the section on family and relationship background.

- Footnote 10 reveals that the review was unable to obtain both Becky and Peter's medical records, this needs further explanation as it is a significant gap.

- The report requires a thorough proofread.

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