THE SAFER BUCKINGHAMSHIRE PARTNERSHIP

Review into the Domestic Abuse-Related Suicide of Robyn in August 2020

OVERVIEW REPORT

By

Becci Seaborne

September 2024

CONTENTS

PREFACE 4
INTRODUCTION AND BACKGROUND 4
BACKGROUND 4
Aim and Purpose of the Review 4
REVIEW TIMESCALES 5
CONFIDENTIALITY 5
TERMS OF REFERENCE 6
Timescales 6
Lines of Enquiry 6
METHODOLOGY 7
CONTRIBUTORS TO THE REVIEW FROM TESTIMONIAL AND COMMUNITY NETWORKS 7
CONTRIBUTORS TO THE REVIEW FROM AGENCY NETWORKS 8
Independent Management Reviews 8
Information Reports 9
Chronologies 9
THE REVIEW PANEL MEMBERS 9
AUTHOR OF THE OVERVIEW REPORT 10
PARALLEL REVIEWS 11
EQUALITY, DIVERSITY AND INTERSECTIONALITY 11
DISSEMINATION 12
REVIEW FINDINGS 13
ROBYN'S BACKGROUND 13
SUMMARY OF THE FACTS 13
CHRONOLOGIES 14
Core Chronology 14
Itinerancy and Rurality 17
AGENCY INVOLVEMENT – OVERVIEW AND ANALYSIS 17
Thames Valley Police (TVP) Involvement with Robyn and Mark – IMR (2020) 17
South Central Ambulance Service (SCAS) Involvement with Robyn – IMR (2018-2020) 21
Health Centre – IMR (2018 – 2020) 22
Milton Keynes Council Children's Social Care (Milton Keynes CSC) – IMR (2018 – 2019) 22
Milton Keynes University Hospital (MKUH) – IMR (2007 – 2018) 22

Oxford University Hospitals Trust (OUH) – IMR (2018) 23
Bedford Children's Social Care (Bedford CSC) – IMR (2008 – 2009) 23
Bedfordshire Police – Information Report (2008) 24
Mark's Background and History 25
CONCLUSIONS AND LESSONS TO BE LEARNT 27
CONCLUSIONS 27
GOOD PRACTICE 28
LESSONS IDENTIFIED 29
RECOMMENDATIONS 30
GLOSSARY 33
APPENDIX 1 35
Crown Prosecution Service – Tests for Prosecuting (Information provided by Thames Valley Police) 35
APPENDIX 2 36
Action Plan 36

PREFACE

1. The author, review panel and Safer Buckinghamshire Partnership offer their sincere condolences to Robyn's family, friends and colleagues. The commitment, through this review, is to continue to work to make the future safer for past, present and future victims and survivors of domestic abuse.

2. The names of all parties in this review have been changed in this report to preserve anonymity. All family members and contributors from the community are identified by pseudonyms, which are listed at paragraph 28.

3. I want to thank Robyn's family for their help and patience during this review. They have expressed a wish for Robyn to be remembered as someone who valued her privacy, was a determined and independent person; very motivated to set a goal and achieve it. She loved animals, and the outdoors. She would help anyone she could, "maybe her heart was too big at times". She would always have time for waifs and strays. She was a kind person. Robyn's family supplied the Chair with three photographs of Robyn; all of these were of her outside, one with a herd of cows, a second with two dogs. These photographs were shown to the review panel.

INTRODUCTION AND BACKGROUND

BACKGROUND

4. This review concerns the circumstances leading to the suicide of a 33-year-old female, Robyn, in August 2020.

5. At the time of Robyn's death, she was 33 and her ethnicity is recorded as White (North European); her partner, Mark, was 40 and his ethnicity is recorded by Thames Valley Police as also White (North European).

Aim and Purpose of the Review

6. This Domestic Abuse-Related Suicide Review examines agency responses and support given to Robyn, a resident of Buckinghamshire prior to the point of her death by suicide in August 2020. According to section 9 of the Domestic Violence, Crime and Victims Act 2004, there is a requirement to review a death by suicide if it is or appears to be as a consequence of the victim being subjected to abusive behaviours within an intimate or family relationship. This process is known as a Domestic Homicide Review (DHR) within the legislation but is referred to here as a Domestic Abuse-Related Suicide Review (DARSR) to reflect more accurately the nature of Robyn's death. This report may occasionally still use the name DHR where this applies to legislation and statutory guidance which is written in this language.

7. Robyn was living in Milton Keynes only weeks before her death and when a domestic abuse incident was reported. The review has taken account of this in the agencies contacted for information, the lessons and recommendations identified, and the dissemination of this report.

8. In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the suicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach in this way, the review seeks to identify appropriate recommendations to make the future safer.

9. Robyn's death by suicide occurred in August 2020 whilst she was in an intimate relationship with Mark. The relationship began in around April 2020 and a report of domestic abuse was made to police in July 2020. Robyn left a suicide note which referenced this relationship and that arguments with Mark contributed to her decision to take her life.

10. The review will consider agencies' contact or involvement with Robyn and Mark during the length of their relationship from April 2020 to August 2020. It will also consider information from agencies from before this time where it is considered to be relevant, for example previous instances of mental health issues or abuse.

11. The key purpose for undertaking reviews such as this one is to enable lessons to be learned from homicides, suicides, or unexplained deaths where there is reason to believe that domestic abuse has been perpetrated and may be linked to the death. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change to address missed opportunities and reduce the risk of such tragedies happening in the future. It is also recognised that good practice should be identified to ensure this continues.

REVIEW TIMESCALES

12. This review was conducted around the following timescales:

- August 2020 – suicide death of Robyn
- 21/09/2020 – decision to commission domestic homicide review
- 21/09/2020 – Home Office notified of decision to commission a domestic homicide review
- 13/01/2021 – First full review panel meeting (the panel has subsequently met on 10 occasions)
- 19/07/2024 – draft overview report agreed by panel
- 18/09/2024 – draft overview report endorsed by Safer Buckinghamshire Partnership

13. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. As the review progressed further information spanning a number of local authorities came to light. Due to the evolving picture of agency contact, some chronologies, reports or independent management reviews were not commissioned until some months into the review. The author has also been mindful to work at the pace of the family when seeking engagement and feedback.

CONFIDENTIALITY

14. All documents and information used to inform the review are confidential and protected by a confidentiality agreement covering all aspects of the review. The findings of the review will remain confidential until the overview report, executive summary and action plan are accepted by Safer Buckinghamshire Partnership and authorised for publishing by the Home Office.

15. Significant dates are obscured in this overview report and the executive summary, and pseudonyms used, to protect the privacy of the individuals concerned.

TERMS OF REFERENCE

Timescales

16. The review considers agency involvement with Robyn and Mark from 2020 when their relationship was understood to have begun, until the death in August 2020. It also considers relevant information relating to agencies' contact with Robyn and Mark outside that time frame as it impacts on agency involvement in this case.

17. Contextual information has been sought in respect of Robyn's background: examples have been sought of relevant contextual information for example previous experiences of abuse, childhood, mental health issues, motherhood etc.

18. Contextual information was also sought in respect of Mark's background; for example, abuse against previous partners or other known individuals, childhood, known relevant offences and/or convictions etc.

Lines of Enquiry

19. The statutory guidance states that the purposes of a Domestic Homicide (or related Suicide) Review are to:

- Establish what lessons could be learnt from domestic homicides regarding the way in which local professionals and organisations work individually, and together, to safeguard victims;
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure domestic abuse is identified and responded to effectively at the earliest opportunity; and
- Contribute to a better understanding of the nature of domestic violence and abuse and to highlight good practice.

20. The finalised lines of enquiry for the terms of reference of this review were:

- To review agency practice and consider how effective they were in identifying and responding to both need and risk for Robyn and Mark, considering, in particular how systems, processes and procedures impacted, and whether these were a help or a hindrance in responding to Robyn or Mark.
- To review multi-agency practice and how effective agencies were in working together to prevent harm and to meet individual's needs, considering, in particular, how systems,

processes and procedures impacted, and whether these were a help or a hindrance in responding to Robyn or Mark.
- To identify areas of good practice in this case.
- To identify improvements to services based on the facts and findings in this review.

21. At the point of signing off the overview report, the chair and the panel identified the weakness in the lines of enquiry contained within the approved terms of reference, due to their generic nature. They acknowledged that, despite this, the review has meaningfully explored many, more specific, lines of enquiry and uncovered significant learning and impactful recommendations, but without going back and formally adding these to the terms of reference. The chair has identified this as a significant learning point in their practice and incorporated this in subsequent reviews.

METHODOLOGY

22. The Safer Buckinghamshire Partnership appointed a chair, Becci Seaborne, who is independent from the matters concerned in this review. Initial scoping was undertaken with relevant agencies to establish chronologies of contact. These were reviewed and further reports commissioned from these agencies where the nature of the contact was relevant to the review. Information received from initial agency scoping also revealed potential new lines of enquiry with additional agencies. This pattern continued for a number of months. Each new agency was approached, and information requested. At each stage the review panel discussed the information available and whether a short report or full independent management review should be commissioned from each agency. Authors of reports submitted to this review were independent of the matters concerned. A summary and analysis of the information received from each agency is provided in the section, 'Agency Involvement – Overview and Analysis', below.

23. The review panel has analysed the chronologies, reports and independent management reviews (IMRs) provided by partner agencies alongside interviews with family members and colleagues of Robyn as identified below. This information has been shared and discussed with the panel through a total of 11 panel meetings between 13th January 2021 and 19th July 2024. Report authors presented their reports at panel meetings where panel members were able to ask clarifying questions and request follow-up information.

CONTRIBUTORS TO THE REVIEW FROM TESTIMONIAL AND COMMUNITY NETWORKS

24. Robyn's parents were notified of the commissioning of the review by Safer Buckinghamshire Partnership who also sent the Home Office 'Domestic Homicide Review' leaflet and information regarding peer support and specialist advocacy from Advocacy After Fatal Domestic Abuse (AAFDA). The Independent Chair contacted the family and has subsequently been in contact with Robyn's sister, Sarah, throughout the period of the review, from December 2020.

25. Sarah explained that her parents did not feel they wished to be in contact with the Independent Chair or contribute directly to the review, but that she would be keeping them informed. She and the Independent Chair have remained in contact by emails, phone calls and online meetings throughout the review process, with regular updates being provided. Sarah was provided with a copy of the terms of reference for the review and was invited to make comments and changes; she indicated she did not wish to make any changes. She has provided direct input into the review through two interviews and numerous conversations via phone

calls and online meetings. The Independent Chair referred Sarah for advocacy support from AAFDA at her request on 5th March 2021 due to ongoing questions the family had about police involvement with the case. She and the Independent Chair have remained in contact with the AAFDA Advocate since that time, holding several online meetings, including two meetings in which a draft version of this report was presented, and feedback later received by the Independent Chair.

26. During 2024, Sarah withdrew from direct engagement with the Chair due to personal circumstances, and her involvement was represented by her AAFDA advocate, including attendance at the final panel meeting on 19th July.

27. Sarah provided introductions and contacts for other members of the family and community who have also been contacted for input. Robyn's former partner, and father of her first child, David, has contributed to the review via a telephone interview. A former employer, Jane, has also contributed by telephone interview.

28. Key people named in this review and/or contributing to it are:

- Robyn's sister, named Sarah in this review
- Robyn's first child, named Sam in this review
- The father of Robyn's first child, named David in this review
- Robyn's second child, named Alex in this review
- Robyn's former employer in Dorset, named Jane in this review

CONTRIBUTORS TO THE REVIEW FROM AGENCY NETWORKS

29. The agencies outlined below were contacted for scoping information to establish what, if any, contact they had with Robyn and/or Mark. The level of information subsequently requested is presented below and was in line with how significant that involvement or contact was, as assessed by the review panel. Four agencies, not listed, confirmed details around contact but no further information was sought by the review.

- Chronology – a list of dates of contact between the agency and the Robyn and/or Mark, with a summary of the nature of that contact and any follow-up actions, referrals or information sharing linked to that contact.
- Information report – a more detailed narrative description to accompany the information provided by the chronology to explain what happened and what actions were taken.
- Independent management review – a full presentation of the agency contact that took place with detailed descriptions of the nature of the contact, actions taken and outcomes of those actions, with an analysis of whether policies and protocols were followed appropriately and whether such policies and protocols were adequate. The analysis covers agency practice and multi-agency working.

Independent Management Reviews

30. The following agencies contributed written chronologies and full independent management reviews:

- Bedfordshire Children's Social Care
- Dorset Police

- Humberside Police
- Health Centre
- Milton Keynes Council - Children's Social Care
- Milton Keynes University Hospital Trust
- Oxford University Hospitals NHS Foundation Trust
- South Central Ambulance Service
- Suffolk Constabulary
- Thames Valley Police

Information Reports

31. The following agencies contributed written chronologies and information reports:

- British Pregnancy Advisory Service
- Derbyshire Constabulary
- Essex Police
- Leicestershire Police
- National Probation Service

Chronologies

32. The following agencies contributed written chronologies and, where relevant, responses to specific questions:

- Bedfordshire Police
- Milton Keynes Council - Adult Social Care
- Northamptonshire Healthcare Trust
- Northamptonshire Police
- Oxford Health Trust

THE REVIEW PANEL MEMBERS

33. The review panel has met 11 times, including to review the independent management reviews and information reports on four occasions and for further discussion and analysis subsequently.

34. At the request of the Independent Chair, Safer Buckinghamshire Partnership has secured specialist suicide prevention input from a relevant professional in addition to the standard agency representation, as identified below.

35. The panel consisted of representatives from the relevant agencies, all of whom confirmed their independence from the circumstances involved in the review. Agencies and roles, rather than names, have been included below following an assessment of potential risk from Robyn's alleged perpetrator, Mark. This review saw records relating to Mark indicating high risk, including stalking and harassment using digital technologies (paragraphs 123-145 refer). The panel is also aware that the draft statutory guidance published in 2024 identifies that panel members should not be named. Whilst this guidance remains in draft form at the time of writing, the panel interprets the statement as a recognition of the potential risks in naming panel members. The panel consisted of the following members:

- Becci Seaborne, Independent Chair and Report Author
- Community Safety Advisor, Buckinghamshire Council (formerly Aylesbury Vale District Council)/Community Safety Partnership
- Domestic Abuse Coordinator, Buckinghamshire Council
- Domestic Abuse and Violence Against Women & Girls Advisor, Buckinghamshire Council/Community Safety Partnership
- Detective Inspector #1, Thames Valley Police Domestic Abuse Investigation Unit
- Detective Inspector #2, Thames Valley Police Domestic Abuse Investigation Unit
- Chief Executive Officer, Local Women's Aid Organisation (from within Thames Valley)
- Designated Nurse for Safeguarding Children and Looked After Children, Buckinghamshire, Oxfordshire & Berkshire West Integrated Care Board (formerly Buckinghamshire Clinical Commissioning Group)
- Public Health Principal (Suicide Prevention), Buckinghamshire Council Public Health
- Associate Director of Social Care, Oxford Health NHS Foundation Trust
- Deputy Chief Nurse, Oxford Health NHS Trust
- Head of Safeguarding, South Central Ambulance Service
- Interim Head of Safeguarding, South Central Ambulance Service
- Interim Safeguarding Professional, South Central Ambulance Service
- Head of Service, Buckinghamshire Council Adult Social Care
- Senior Operational Support Manager, National Probation Service

AUTHOR OF THE OVERVIEW REPORT

36. The independent chair and author is Becci Seaborne. Becci has no current or recent professional or personal relationship with any of the agencies involved in this case, those represented on the panel, nor with the Safer Buckinghamshire Partnership. She worked for Thames Valley Police between 1998 and 1999 and for Thames Valley Probation between 2002 and 2004; she held a role working in close partnership with both agencies between 2013 and 2017 (Restorative Justice Manager), however this was not linked to work on domestic abuse and did not involve relationships with any officers involved in Robyn's case or on the review panel.

37. Becci was a Trustee for AAFDA from 2019 until January 2024 and declared this upon appointment, and again when she referred Robyn's sister, Sarah, to AAFDA. An open and candid discussion took place between Sarah, the Independent Chair and the AAFDA Advocate to ensure that the necessary 'ethical walls' were in place to protect the privacy of Sarah and to check she felt satisfied with the situation. It was also explained and agreed how she could raise concerns or complaints about either party safely if required. She indicated she was satisfied with these arrangements. The Safer Buckinghamshire Partnership was notified, as were the Chair of Trustees, the Chief Executive Officer and the Operations Manager at AAFDA.

38. Becci has a relevant career spanning 22 years in the third and public sectors. During this time, she has worked in front line roles with victims and survivors of domestic and sexual abuse, and with people with offending histories and high-risk perpetrators. She has also worked in a range of management and governance roles involving service provision for domestic abuse, substance misuse, offending behaviour, high risk offending, mental health, and restorative justice. Her career includes nine years working in supported housing, seven in criminal justice, and six years specialising in domestic abuse since 2017. She spent two years as manager for the specialist domestic abuse services in Oxfordshire and West Berkshire until 2019. During this time, she was a panel member in five Domestic Homicide Reviews as a domestic abuse specialist. She has worked as an independent specialist, including domestic abuse training and

consultancy, since then. Becci has undertaken the Home Office online DHR training and the accredited DHR Chair training delivered by AAFDA, and led the work to establish and launch the national DHR Network, hosted by AAFDA.

PARALLEL REVIEWS

39. An inquest was held in late 2020. A recording of the hearing has been received confirming a conclusion of death by suicide. A police investigation into coercive control was concluded in September 2020 with no further action taken.

40. Due to the ongoing domestic abuse investigation by TVP at the time of Robyn's death, the matter was referred to the Thames Valley Police Professional Standards Department and Independent Office for Police Conduct (IOPC). The Professional Standards Department found no misconduct, and this was agreed by the IOPC.

41. In March 2021 the review chair introduced the family to Advocacy After Fatal Domestic Abuse in response to unanswered questions regarding police activity following Robyn's death. They liaised with Thames Valley Police, and an internal review into the police activity following Robyn's death was completed. A summary of the findings of the review was received by this domestic abuse related suicide review in October 2022 and is introduced in the relevant section of this report.

EQUALITY, DIVERSITY AND INTERSECTIONALITY

42. It is important, in the context of domestic abuse, to understand a victim's experiences of discrimination, stigma and/or oppression across the whole of their life's experience. These experiences significantly impact on a person's experience of the abuse specifically, their visibility to services, and their ability to cope and seek help. A person's specific experiences of discrimination, stigma, and oppression in all forms combine to create a unique impact, and a complex pattern of barriers in relation to disclosing abuse or other needs, and in seeking help.

43. The review panel is alive to the need to understand how these issues may have affected Robyn, and as such must consider her status with each of the nine protected characteristics defined in the Equality Act 2010 and any other factors which may be relevant to our understanding of her life experiences. These protected characteristics are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

44. Robyn's sex is recorded as female and she reported her gender as the same. She was 33 years old, unmarried and cohabiting[1] with her partner at the time of her death and had at least one previous long-term relationship with the father of her first child. She would have been approximately 18 years old when this relationship began and 20 years old when she had her first baby. She was 31 years old when she had her second baby. Her known relationship history is with men; this review has not seen any documented records which identify a reporting of her sexuality. There is no known record of her religion, although her family describe her as not religious; her ethnicity is recorded by Thames Valley Police as White, North European. In respect of maternity, records show that Robyn two live births, one in 2007 and

[1] The word 'cohabiting' is used here to describe the fact that Robyn was living with Mark at the time of her death, however her family raise the issue that there is evidence to suggest that this arrangement was coerced rather than a free choice on Robyn's part.

one in 2018. Fulltime care of her first child, Sam, transferred to the father, David, when Sam was around 12 months old. Robyn opted for adoption for her second child. They were placed into local authority care on the day of their birth. This review will consider all issues relating to Robyn's experiences of pregnancy, giving birth and motherhood. There is no statement in any documented records made available to this review that Robyn experienced any difference in her physical or intellectual abilities. There is documented evidence of her experiencing depression. Linked to this, the review identifies the importance of exploring Robyn's experiences around physical and mental health. The relevance and impacts of all the factors mentioned here will be examined as they arise throughout the report.

45. There are additional factors in this case which the review panel assesses as impacting Robyn's intersectional experiences:
    - Trauma
    - Physical and mental health
    - Income and financial stability,
    - Housing stability and itinerant lifestyle,
    - Isolation and rurality
    - Coronavirus (Covid-19) lockdown, and
    - Criminality and offending behaviour (of Mark).

46. The review has taken care to consider these factors in combination, as identified in the conclusions.

DISSEMINATION

47. The following agencies and individuals will receive a copy of this overview report:
    - Robyn's family
    - All agencies directly affected by this review, including those who have provided information
    - The Office of the Police and Crime Commissioner, Thames Valley
    - Buckinghamshire Safeguarding Adult Board
    - Buckinghamshire Safeguarding Children Partnership
    - Buckinghamshire Domestic Abuse Partnership Board
    - Buckinghamshire Multi-Agency Suicide Prevention Group
    - Milton Keynes Safeguarding Boards
    - Milton Keynes Domestic Abuse Partnership Board [?]
    - MK Together
    - Office of the Domestic Abuse Commissioner

48. The overview report and/or the executive summary will be published as follows:
    - Buckinghamshire Council website
    - Buckinghamshire Domestic Abuse Partnership (BucksDAP) website

REVIEW FINDINGS

ROBYN'S BACKGROUND

49. Robyn loved animals and used to enjoy drawing horses and dogs in particular, often saying she preferred them to people. She was also described as 'bubbly' and 'chatty' before she met Mark, enjoying karaoke and socialising in pubs. In other ways she seemed to value her privacy and independence; preferences which seemed to be more prominent later in her life. Since her relationship with Mark began around the time of the coronavirus (Covid-19) pandemic and a national lockdown, it is not simple to understand which of the two may have had more impact on her behaviour. Her employer at the time, however, has described her behaviour and demeanour as changing almost as soon as he arrived, so it is reasonable to make the link to his influence. We cannot be certain, but also acknowledge the impact that some of the traumatic events in her adult life, building on her early experiences, may well have had on these choices.

50. From accounts given by her sister, a former partner and former employers, we have a picture of Robyn as having lived with some challenging home circumstances and bullying at school as a child. She left home early and took up itinerant agricultural work for most of her life, latterly working on dairy farms.

51. Robyn met the father of her first child in 2005 and gave birth in 2008. David described Robyn as experiencing post-natal depression at this time. By 2009 their child was living with David and there are conflicting reports about how that came to be the case. It is identified as 'traumatic' for her in some records, and she describes it as feeling she had her child taken away from her in other accounts and began attempts to re-establish contact in 2014. In 2018 Robyn experiences an unplanned pregnancy and places her second child, Alex, into adoption.

52. To the best of our knowledge, Robyn had little interaction with agencies or services throughout her life other than when unavoidable (e.g., health and pregnancy). We observe a tendency toward declining offers of support around mental health, with one exception in 2015. We remain mindful of the many barriers to seeking and accepting mental health support, although no reasons or curiosity around this are ever documented for Robyn in the records seen by this review.

SUMMARY OF THE FACTS

53. Robyn and Mark met and began a relationship together whilst she was living and working at a dairy farm in Dorset in early 2020. They moved from Dorset to Milton Keynes very suddenly in late June/early July where they lived in a caravan on the driveway of Robyn's parents' home. A report of a domestic abuse assault was made by Robyn, via her father, against Mark to police in July 2020. Robyn stated to police that she was leaving the relationship, but shortly afterwards the caravan was moved to an isolated field on a campsite in Buckinghamshire, where Robyn and Mark both lived until her death in the August. No-one else resided there with them.

54. In August 2020 Mark placed an emergency call to report Robyn's death. Police attending the scene found a note by Robyn referring to her relationship with Mark and mentioning their arguments as contributing to her decision to take her life. They determined her death to be a 'Sudden Death: Unexplained Death' and this reference in her note was the basis for assessing her death met the criteria for a review. The coroner reached a verdict of suicide at an inquest

held in late 2020. A police investigation into coercive control was concluded in September 2020 with no further action taken. Robyn's family had concerns about a history of domestic abuse, including coercively controlling behaviour towards Robyn, and there was a further police review, at their request, during 2021-22. That review also considered the issue of Mark's culpability for Robyn's death due to domestic abuse, including coercively controlling behaviour, but concluded there was not sufficient evidence to bring a case.

CHRONOLOGIES

Core Chronology

55. There follows a chronology of Robyn's and Mark's interaction with services before and during their relationship. Entries from before the commencement of their relationship have been carefully assessed for relevance. They are included where the panel conclude they are significant to factors of intersectionality, protected characteristics and their potential impact on experiences of abuse.

Early Years – Before 2005

56. Robyn has a challenging home life as a child, including conflict between her parents, and is bullied at school. She leaves home at 15 years old and moves around frequently for work, moving to and from the parental home and sometimes living in caravans.

2005 – 2008: Former Long-Term Relationship and First Maternity/Motherhood Period

57. **2005:** Robyn and David meet and begin a relationship.

58. **2007:** Robyn becomes pregnant and has a difficult pregnancy with bleeding throughout and severe morning sickness. She gives birth to Sam in mid-2007 by emergency Caesarean section; David is entered on the birth certificate as the father. Following the birth Robyn's mental health begins to decline, and their relationship deteriorates.

59. **2008:** Robyn's mental health continues to decline. The police are called to two domestic abuse incidents in which she is reported as the alleged perpetrator. In the first, the police observe that she exhibits bruises but there is no documentation of this being followed up with her. In the second, the police determine no offence has been committed.

2008 – 2017: Separation from Partner and Child and Beyond

60. **2008:** Robyn and David separate and Sam stays in the care of David; there are mixed accounts of how this comes to take place.

61. **2009:** In January David calls Children's Social Care to confirm Sam is now in his full-time care.

62. **2010:** Robyn attempts to reinstate contact with Sam, through solicitors.

63. **2014:** Robyn reports to police that in 2009 her former partner failed to return their child to her care after a contact visit. Since he had parental responsibility police did not record this as a crime but advised her to pursue the matter through the Family Court.

64. **2015:** Robyn experiences severe back pain which leads to many health consultations and a period signed off work. It also leads to a period of depression for which she is referred to a counsellor and attends one documented session.

2018: Second Maternity – Antenatal Care & Birth

65. **February:** Robyn discovers she is pregnant following an emergency admission to hospital for abdominal pain, vomiting and diarrhoea. Assessment of gestation is not recorded.

66. **Early-mid 2018:** Robyn seeks to adjust to the news she is pregnant and explores her options. Robyn experiences mental health issues during this time and expresses suicidal ideation. A mental health referral is made; however, Robyn declines any support. Her mental health is noted to improve somewhat. Robyn experiences a difficult pregnancy, requiring periods signed off work for vomiting and exhaustion. This results in a second emergency admission which also triggers a safeguarding referral due to concerns about her living conditions. No record relating to Robyn is identified by Milton Keynes Adult Social Care in this respect. Her unborn baby is assessed as needing Children's Social Care support as a 'child in need.'[2] She decides to opt for adoption for the baby.

67. **Mid-2018:** Robyn gives birth early by emergency Caesarean section and her child, Alex, is immediately placed in local authority care for adoption. She gives her first child's name, Sam, to Alex as a middle name. She engages with the adoption team on several occasions to provide information for Alex in the future.

2018 – 2019: Second Maternity – Postnatal Care and Adoption

68. **2018:** Robyn sees a GP for a number of birth-related health issues and also reports feeling depressed but declines a counselling referral. She continues to see the adoption team to provide information for her child. They note concerns for her mental health, but she declines support for this.

69. **2019:** Robyn's GP surgery write to her twice to follow-up about her depression. There is no documented response from her, nor any further action by the surgery.

2020: Robyn's Relationship with Mark and Her Suicide

70. **2010-2019:** Mark has a history of domestic-related incidents including alleged assaults, harassment and sexual assaults.

71. **January-March 2020:** Robyn and Mark meet in January, begin a relationship in February, and he moves to live with Robyn at her workplace in March. In March the first coronavirus (Covid-19) lockdown is announced.

72. **March/April:** Robyn's employer at the time (a dairy farmer in Dorset), Jane, reports that Mark moves in around March 2020 and that Robyn's behaviour and demeanour deteriorates at this point. She reports hearing loud arguments between Robyn and Mark from the next-door bungalow where they live, on several occasions. Her husband attempts to remove Mark from the premises on at least one occasion, but he returns within a day or two. Her daughter contacts Robyn's sister stating that her mother, the employer, is trying to find someone to

[2] Under section 17 of the Children Act 1989, Children's Social Care is obliged to provide appropriate support in enabling families to safeguard and promote the child's welfare where they are assessed as being a 'child in need' under that section of the Act.

speak to about Robyn as she is worried about her. Sarah takes up a conversation with the employer in which she is advised they have witnessed a marked change in Robyn's behaviour and demeanour since Mark has moved in with her. They are concerned about Robyn and feel Mark is dangerous to her.

73. **June:** Robyn and Mark leave the farm where she is working in the middle of the night, having given no notice or prior indication they intended to leave.

74. **July:** A few days later, in early July, they arrive with a caravan at Robyn's parents' address and stay there on the driveway.

75. On 16th Robyn's father reports a domestic abuse assault to the police. Mark is the alleged perpetrator against Robyn. Police attend: Mark has already left and they spend time with Robyn taking her statement and completing a risk assessment (known as a DOM5). She advises the officer that she is receiving communications from Mark already that day.

76. Robyn continues to receive numerous communications from Mark which she does not respond to. She remains in email contact with the officer in the case, discussing the case expressing her concerns about Mark. She tells the officer in the case she thinks pressing charges will make things worse. The officer is responsive and sympathetic to her situation. They reassure her about the robustness of their approach to Mark, identifying ways to protect her, such as bail conditions or a Domestic Violence Protection Notice (DVPN). The criteria for a DVPN are never met since Mark is never arrested. The officer is investigating possible coercive control.

77. **Late July:** In the last week in July, about a week after the assault, Robyn puts into action a plan to move the caravan without Mark's knowledge so that she can be closer to work at a nearby farm and to live somewhere that Mark had no knowledge of her location. Shortly after this move her parents visit the caravan and upon leaving, they see Mark pull up in his car. On seeing them, he performs a U-turn in the car and drives off to wait in a layby. When they later ask Robyn about this they are requested to "mind your own business." Their response is to let her know that they are there if she needs them but, in the meantime, they will leave her alone. Sarah reports that Robyn initially moves the caravan to a location in the field near facilities, but by the time of her death Mark has insisted on moving the caravan to a bottom corner of the field where it is out of sight and has no access to basic facilities.

78. **August:** A week before Robyn's death, she visits her parents and tells them she has a new job in Dorset and plans to use this as a chance to get away from Mark. She makes a plan to settle into the new job for a few days and then return to her parents to collect her cats.
79. **5 days before Robyn's death:** The officer in the case emails Mark and requests a voluntary interview with him.

80. **4 days before Robyn's death:** Robyn calls police asking to speak with the officer in the case asking to withdraw her statement and stating they have renewed the relationship. The officer emails Robyn three hours later stating that he has tried to call her. The officer acknowledges Robyn wants to drop the case but states he has invited Mark to attend on a voluntary basis and this needs to still go ahead.

81. **2-3 days before Robyn's death:** There is a further email conversation between Robyn and the officer in the case; she wishes to meet with him urgently and he offers a conditional time to meet. He carefully advises Robyn that if he is called away to urgent duties, he will need to

postpone their meeting, he enquires about the nature of the urgency so that he might advise her appropriately and advises her to call 999 in an emergency. There is no further response from Robyn.

82. **2 days before Robyn's death:** Robyn's parents receive a text in relation to her plan to get away from Mark and take up employment in Dorset. She advises she will not be coming that day as planned because the storms are too bad, and she doesn't want to drive in them.

83. **The day of Robyn's death:** Mark places a 999 call; on returning from shopping, he has found Robyn hanging and unresponsive. He has cut the 'rope' and dialled 999. The Air Ambulance also attended and confirmed no life. Robyn is reported to have died by hanging, her death being recorded at the time as a 'Sudden Death: Unexplained Death', subsequently ruled as a suicide.

84. **One day after Robyn's death:** Mark emails the officer in the case of the domestic abuse assault on 16/07/2020 requesting to meet. Mark indicates that prior to her death, Robyn and he had attended so they could speak with police together regarding the 16/07/2020 assault. Records are checked but no entries are found to verify this. Arrangements are made for him to attend for interview.

85. **September:** Mark attends on 15th for a voluntary interview in relation to the assault on 16/07/2020 and coercive control of Robyn. He provides a prepared statement denying the allegations and providing an alternative version of events which includes indicating that Robyn was the aggressor in the altercation on 16/07/2020. On advice from the Domestic Abuse Investigation Unit, a subsequent decision of no further action was taken, and Mark informed.

Itinerancy and Rurality

86. Information from the agency chronologies received by this review demonstrates a pattern of rurality and itinerancy in Robyn's living arrangements. This represents a minimum of ten relocations across at least seven counties in the 11 years between 2009 to 2020. The locations range from the south-west to the south-east to the east midlands.

AGENCY INVOLVEMENT – OVERVIEW AND ANALYSIS

Thames Valley Police (TVP) Involvement with Robyn and Mark – IMR (2020)

Overview

87. In March 2014, Robyn contacted TVP stating that in 2009 her estranged former partner had taken their child out for the day and had not returned the child. She stated that she was making Child Support Agency payments and was seeking advice. Police contacted Robyn who advised she used solicitors in 2010 to attempt to reinstate contact. Following enquiries with Police and Children's Social Care in Bedfordshire, the officer in the case concluded no crime had been committed since the father had parental responsibility, and advice was given to pursue the matter through the family court.

88. In July 2020, a domestic abuse assault was reported to police by Robyn's father as a third party. The call handler recorded a crime of Assault Occasioning Actual Bodily Harm and police attended the scene and the suspect, Mark, had already left. The officer in the case took a

statement from the victim, Robyn, and completed a DOM5[3], and adding a crime of Coercive Control in light of information provided. The risk level was recorded as medium[4] and Robyn expressed that she was ending the relationship. During the time the officer was present with Robyn, she was already receiving a number of messages from Mark apologising and seeking reconciliation, of which she made them aware.

89. The independent management review identifies the appropriateness of the risk grading and the level of detail recorded in this process. In particular, the officer highlights the presence of controlling and jealous behaviour and that the present incident represented an escalation as the first instance of physical violence. The officer also recorded Robyn's reporting of depression and being very frightened since Mark had not been violent before and they had not separated before. The independent management review identifies that safety planning on the day was appropriate and included a referral to a victim support service, which Robyn declined. The DOM5 records that Robyn was unaware of Mark's domestic abuse history. A summary is provided in the report but was not provided to Robyn.

90. The officer established through the automatic numberplate recognition system (ANPR) that Mark had travelled a considerable distance away, but he was not flagged for immediate arrest, the officer in the case instead being tasked with ongoing enquiries and submission of a 'wanted' file (flagging him for arrest) later if required. This was in line with policy given the assessment of no imminent risk to Robyn.

91. In line with TVP protocol in domestic abuse cases, the incident triggered the creation of a 'risk management occurrence'[5] on the system, which prompted allocation of an action to a 'queue' for the relevant team. There were a number of such queues in operation at this time:

- The 'vulnerability queue' was a queue set up during the Covid-19 lockdown by Milton Keynes Local Police Area to provide a response to medium-risk domestic abuse victims during coronavirus (Covid-19) lockdown restrictions.
- There was a 'domestic abuse safety planners' queue which had been set to create separation from the DAIU queue where cases would have been mixed in with high-risk cases.
- The Domestic Abuse Investigation Unit (DAIU) queue was dedicated to high-risk victims and was monitored and actioned by officers within the unit.

92. Two 'occurrences' now existed on TVP systems; the risk management occurrence, and the assault itself (the crime being investigated). The risk management occurrence was allocated to the vulnerability queue. It was updated by a police sergeant to say that no contact was required since ownership remained with the officer in the case, in line with procedure. The assault occurrence was allocated to the Domestic Abuse Investigation Unit (DAIU) and was closed since it had been assessed as medium risk which did not meet the threshold for DAIU (i.e., high-risk).

[3] The DOM5 is a domestic abuse risk indicator checklist (adapted for use by Thames Valley Police from the DASH).
[4] Medium Risk - evidence of identifiable indicators of risk of harm; the offender could cause harm but is not likely to do so unless there is a change in circumstances.
[5] 'Risk management occurrence' is a police term used to describe the way they identify and log an incident they are dealing with when it requires active risk management activity, e.g., safety planning in cases of domestic abuse.

93. Robyn's case was not allocated to the domestic abuse safety planners' queue where, as a medium risk case, an Independent Domestic Violence Advocate (IDVA) would have picked up the safety planning activity. In addition, the IDVA responsible for this worked 2 days a week at that time and so was not contacting all medium risk victims due to issues of capacity. In summary, two aspects of the process did not work as intended for Robyn.

94. It was entered in the log that as the suspect had not yet been arrested, safety planning remained the responsibility of the officer in the case in line with standard procedure in such cases. The initial safety planning was completed by the officer at the time of attendance and officers would expect to deal with and respond to continued risk during an ongoing case such as through the management of bail, etc.

95. Robyn and the officer in the case communicated by email over the following days. Robyn expressed increasing concerns about going ahead with a complaint, stating she felt it would make things worse and that they had made up. By mid-August 2020 Robyn was expressing an urgent need to see the officer in the case, and they were engaged with her in trying to arrange a meeting, whilst advising they may be called to urgent duties. In the final contact recorded (email), the officer asked about the urgency expressed by Robyn so they might assess their response, and appropriately referred her to the use of 999 in an emergency. There is no further response from Robyn or contact between the two.

96. In August 2020 Mark placed an emergency (999) call to report that he had returned to find Robyn dead inside the home. Response officers attended the scene and received advice from CID until they were able to attend; scenes of crime officers also attended. Robyn's suicide note and the ligature were seized as evidence.

Analysis

97. According to the IMR author, subsequent IMRs in other cases have highlighted the lack of ownership around risk management occurrences, as described in the overview section here. It has been identified that they tend to serve as a tool for recording actions rather than monitoring and addressing risk and this is being looked at by the Policing Strategy Unit. Information provided through the IMR and panel members does identify the complexity of the processes sitting around and driving the responses to domestic abuse victims. This might indicate a vulnerability to 'gaps' in practice. Since Robyn's death, a commissioned service was brought in to undertake safety planning for medium-risk victims of domestic abuse across the whole Thames Valley area. This is no longer operating so investigating officers currently have responsibility for safety planning. This remains a gap, therefore, in terms of ownership and accountability, and of specialist domestic abuse input into this process.

98. Following the domestic abuse assault, which also identified coercively controlling behaviour by Mark, Robyn was offered a referral to Victims First. A specialist domestic abuse service may have been more appropriate given the risk level (medium). Victims First is a force-wide service which operates, in part, as a gateway to more specialist services as well as offering some specialist services 'in-house' and therefore offers the most straight forward referral route to a response officer for victims. However, it is well documented that experiencing re-direction or signposting presents a barrier for victims of domestic abuse and that they need the most specialist and relevant support at the earliest possible opportunity. Milton Keynes benefits from the services of MK-ACT, a provider of a range of specialist domestic abuse services, who would have been well placed to support Robyn should she have felt able to engage at that time. It may be that the officer in the case was not aware of any of these facts or resources

and if this was the case, the Victims First referral offer would be in line with standard practice. This review has identified the complexity of service provision and of the referral pathways for victims of domestic abuse. This creates barriers to their help-seeking. It also presents significant challenges for frontline professionals in possessing accurate and up-to-date information about the most relevant support services available for victims.

99. It was apparent early on that Mark was attempting to make contact with Robyn, which would be consistent with the 'reconciliation' phase in the cycle of abuse[6]. Mark has a documented history of alleged post-separation harassment. This was a potential indicator that significant coercion and pressure would be placed on Robyn to resume/continue the relationship. There are options available to police in these situations to create safe 'space for action'[7] for victims, such as Domestic Violence Prevention Notices and Orders (DVPNs and DVPOs)[8]. Although the officer mentions a DVPN to Robyn, this is not discussed further or implemented because Mark is not arrested. Robyn was advised to block Mark's messages which seems logical on face value. However, learning from other Domestic Homicide Reviews has identified that this can escalate rather than mitigate risk, and good practice guidance states this advice should not routinely be given. The IMR author identifies that Thames Valley Police Operational guidance is slightly contradictory on this point, stating, "Block the perpetrator (and anyone associated with them) on social networking sites", but elsewhere stating, "Maintaining some contact may prevent the risks escalating further." Information from the College of Policing is also ambiguous and it is clear that on such a complex and nuanced issue, there is some risk giving blanket advice; for example, the best advice might differ between harassment cases and stalking.

100. The officer in the case identified that Robyn was not aware of Mark's history of domestic abuse and violence and explained to her the right to ask under the Domestic Violence Disclosure Scheme (Clare's Law). The IMR identifies that he was not aware he could initiate a 'right to know' process in which he would be able to proactively make a referral to seek a decision to make a disclosure[9]. In Robyn's case it is unclear what information it might have been possible to share and whether this would have been impactful for Robyn in the situation.

101. Notwithstanding the above observations, the officer in the case shows a victim-focused approach, being responsive and validating whilst being realistic about his ability to engage with immediacy.

---

[6] The 'cycle of abuse' is a well-established feature of abusive relationships, especially where coercive control is present, whereby the abuser cycles through periods of building tension, followed by an incident or crisis point, then reconciliation and calm before the cycle begins again. The reconciliation point is high stakes for the abuser who will employ significant amounts of psychological coercion to reconcile with the victim, especially if there is any indication they may be considering separation. One of the effects of the continuous cycle of abuse is trauma bonding which makes it biochemically, psychologically and physiologically almost impossible for the victim to leave the relationship.

[7] 'Space for action' is the idea that within a relationship with an abuser, the victim/survivor is living in a permanent threat-response state where their capacity to think independently and plan escape is prevented by the tactics of the abuser. Professionals have a role and a duty in disrupting the behaviour of the abuser and removing them from the situation to create opportunities for support and 'space for action' for the victim whilst the abuser has less influence and impact in their day-to-day life.

[8] A DVPN can be served by the police on perpetrators of domestic abuse if they are arrested and provides emergency protection for victims – see glossary for more details.

[9] Under 'Clare's Law, someone has a right to know (as well as a right to ask), which places a responsibility on professionals possessing knowledge of a domestic abuse history to trigger a process leading to a disclosure of appropriate information to the partner of that person. The extent of the information disclosed, by whom, and how, is assessed on a case-by-case basis within the Policing area handling the issue.

102. A subsequent, internal review was completed looking into police activity following Robyn's death. That review concluded that opportunities to secure evidence relating to possible domestic abuse and/or coercive control, were lost due to the focus on the immediate circumstances of the death and not the wider picture of the abuse that Robyn may have been subjected to. In particular, it is noted that information provided by the family immediately after her death may have provided early justification to arrest Mark, which would have enabled searches and seizures of property. This could have provided evidence. The review also considered the bearing of the domestic abuse on Robyn's decision to take her life and whether there was criminal case to be made. However, the reviewing officer concluded that there was not enough evidence to pursue this.

South Central Ambulance Service (SCAS) Involvement with Robyn – IMR (2018-2020)

Overview

103. Mark was not known to SCAS and Robyn had limited contact with them. She placed three non-emergency (111) calls with SCAS between February 2018 and March 2020. During the first of these calls Robyn was advised to attend an out of hours GP which resulted in her being taken by ambulance to the Emergency Department, whereupon her pregnancy was detected.

104. She placed one emergency (999) call with SCAS on 16/05/2018 reporting nausea and vomiting whilst pregnant. They dispatched an ambulance to take her to the Oxford University Hospital Emergency Department. Ambulance crew noted concerns about her poor living conditions and her distress about the unwanted pregnancy. They passed this information on to hospital staff who agreed to undertake the necessary safeguarding referral. The independent management review notes that protocol states ambulance crew, when the originators of a safeguarding concern, should be the ones to complete the referral and this is identified as a gap in practice. Records show that hospital staff did follow-up the safeguarding concern and the referral was made.

105. Mark placed an emergency (999) call in the second half of August 2020 upon returning home to find Robyn lifeless. SCAS attended the scene and a helicopter emergency medical service (HEMS) Air Ambulance also attended.

Analysis

106. The ambulance service had limited interaction with Robyn, but a point of interest for this review focuses on the safeguarding concern identified by crew on 16/05/2018 which was not referred directly by them in line with standard procedure. It is important to acknowledge that the crew did identify concerns for her and raised these with other professionals. The concerns were handed over to Oxford University Hospitals staff at the Emergency Department (ED) who did make the safeguarding referral. Panel discussions on this matter identified that in general the Multi-Agency Safeguarding Hub (MASH)[10] has a high volume of duplicate referrals from SCAS and the Emergency Department, which indicates there is not a systemic gap in operating procedures. There is ongoing work around making this process more effective. The relevant panel member advises that the likely outcome would have been an assessment of Robyn not

[10] The Multi-Agency Safeguarding Hub is a team of professionals from children's social care, police, health and other agencies who deal with concerns about the safety and wellbeing of a child. It offers assessments, early intervention, advice and support to children and families.

meeting the threshold for intervention but a referral to Children's Social Care due to the unborn baby; these outcomes were realised in any event.

107. We are aware there is ongoing work on staff development to address issues around this process.

Health Centre – IMR (2018 – 2020)

Overview

108. Robyn registered with the Health Centre on 12/06/2018, part-way though her second pregnancy and remained registered there until her death. They wrote to her twice in 2019 to follow up about her depression. There is no documented response to their letters or any further action in relation to this matter. The last time she attended the surgery was in October 2019 (for a matter unrelated to this review), after the depression monitoring letters were sent. There is no documented record of the depression being discussed at this appointment.

Analysis

109. Robyn had limited interactions with the GP practice and no direct contact with a health practitioner during the time of her relationship with Mark. However, the care and treatment relating to her depression is identified as potentially having a bearing on her wellbeing, resilience and coping strategies as she entered that relationship and as it developed. Depression monitoring letters were sent, but depression was not raised at a subsequent appointment with a nurse practitioner at the surgery.

Milton Keynes Council Children's Social Care (Milton Keynes CSC) – IMR (2018 – 2019)

Overview

110. Milton Keynes CSC hold records for Robyn in relation to the adoption of her second child in 2018. Robyn engaged with the adoption team to provide information for her child in the future and chose to step back from this near the end of 2018. The social worker noted concerns for Robyn's mental health and discussed this with her; she declined any support.

Analysis

111. Social workers from the adoption team showed and documented due concern for Robyn's wellbeing. Whilst a different outcome might have been desirable in the eyes of professionals, and particularly with hindsight, Robyn was at liberty to make her own choices about access to support for mental health. The social worker had discussed this with her and so she was aware support was available if she wished to access it. We are, however, mindful that despite this, there remain many barriers to accessing such support, such as previous experiences of trauma and/or being let down by others, resulting in low levels of trust.

Milton Keynes University Hospital (MKUH) – IMR (2007 – 2018)

Overview

112. Robyn gave birth to both her children at Milton Keynes University Hospital. They hold the records of these births in 2007 and 2018 and some maternity records, whilst others are held

by community-based services. They have no record of her attending their Emergency Department.

113. In addition to presenting for the births, Robyn's antenatal maternity care was transferred from Oxford University Hospitals to MKU on 13/06/2018 following her move out of Oxfordshire around 21/05/2018. She attended four appointments with MKUH staff in June and July of 2018 for a maternity booking appointment and further maternity assessments. Three of these were at the hospital and one was at her parents' home.

Analysis

114. The MKUH independent management review (IMR) reveals that Robyn's antenatal care was in line with standard midwifery and obstetric practice. The IMR highlights good practice in the identification of potential complications due to Robyn's late presentation with the pregnancy and the disclosure of the use of cannabis, along with her unstable living circumstances, being accommodated through the employment she was about to lose. This resulted in her being referred to the Safeguarding Lead Midwife who visited her at her parents' home. Ultimately, there was no safeguarding activity for Robyn. She had capacity and declined mental health support. For her unborn baby an assessment ensured statutory involvement going forward, although this was subsequently made unnecessary by the adoption.

Oxford University Hospitals Trust (OUH) – IMR (2018)

Overview

115. Robyn attended the OUH Emergency Department on 18/02/2018, when her second pregnancy was identified for the first time. Following that she attended her maternity booking appointment with them on 15/05/2018 and attended the Emergency Department again on 16/05/2018. She was admitted and received a psychiatric assessment whilst still an inpatient on 17/05/2018. Her antenatal maternity care was then transferred to Milton Keynes University Hospital when she moved home.

Analysis

116. The OUH independent management review (IMR) describes practice in line with policy and required standards in most areas. OUH did not interact with Robyn during the time of her relationship with Mark, but they have highlighted the significance of professional curiosity around domestic abuse. They note the need to ask and record the responses of patients to 'difficult questions', (including when responses were not made), which was not demonstrated in her case.

Bedford Children's Social Care (Bedford CSC) – IMR (2008 – 2009)

Overview

117. Bedford CSC have records for Robyn in the context of her relationship with David and their child. These records represent three 'contacts' between May 2008 and December 2009. On two occasions in 2008 (May and July), Bedfordshire Police were called out to domestic incidents and made safeguarding referrals to Bedford CSC on the basis of domestic abuse.

118. In December 2009, Bedford CSC recorded a contact from David advising he was taking over the full-time care of their child and that he has parental responsibility as the father named on the birth certificate.

Analysis

119. Bedford CSC did not open a case for Robyn's child on any of the three occasions they came to their attention. This would not have been necessary in the last instance, and it is likely that incidents referred by the police did not meet the threshold for child protection involvement. In any event, Social Care practice has changed considerably in the intervening 12 years. Most significantly, Multi-Agency Safeguarding Hubs were introduced in 2011 and radically changed the response to safeguarding concerns and multi-agency responses. Any analysis or recommendations likely to emerge from practice before that time would now, therefore, be irrelevant.

Bedfordshire Police – Information Report (2008)

Overview

120. In May and July 2008, Bedfordshire Police were called to domestic incidents involving David and Robyn; on both occasions Robyn was recorded as the suspect. In the May incident, injuries to Robyn were also observed and recorded, but no discussion of their cause was documented. Records indicate David did not wish to pursue a complaint against her on this occasion. The July incident was recorded as a 'non-crime', meaning the behaviour (or what could be determined from the testimony given) did not reach the threshold of a criminal offence. On both occasions the relevant safeguarding referrals were made, in line with policy.

Analysis

121. There is no documented evidence of Bedfordshire police having used a separate/private debrief with Robyn to establish the cause of her apparent injuries. This is of particular concern given that, although females are known to perpetrate domestic abuse, statistically they are much more likely to be the victim. Additionally, Johnson[11] identifies violent resistance as a form of domestic abuse where the victim who is subject to a pattern of abuse (most typically coercive control but including psychological and physical abuse) is manipulated into retaliation. It is known in domestic abuse support services for victims of domestic abuse to have arrests, cautions and convictions for domestic abuse assaults in this context.

122. Whilst it remains important for statutory agency responses to be informed by knowledge of these dynamics of domestic abuse, the incidents described here occurred more than 12 years ago, and outside the geographic area of this review. Many changes and advancements have been made in police responses to domestic abuse across the UK in the intervening years, for example Bedfordshire Police were early adopters of the SafeLives 'DA Matters'[12] training programme for officers in 2017. Hence, the relevance of any further analysis or recommendation in relation to these incidents is limited.

[11]Johnson, Michael P. (2008). A typology of domestic violence: Intimate terrorism, violent resistance, and situational couple violence. Boston Hanover, New Hampshire: Northeastern University Press.
[12] https://safelives.org.uk/training/police

Mark's Background and History

Overview

123. The presence of stalking behaviour, mental health issues, self-harm/suicidality of the perpetrator, credible threats to kill and use of weapons are high-risk identifiers in the DASH[13]. Furthermore, according to Dr Jane Monckton Smith et al, a pre-relationship history of stalking or abuse by the perpetrator is step one in the eight-step timeline to domestic homicide, which is also shown to apply to suicides relating to domestic abuse[14]. It is also understood that the prevention of domestic abuse and of future victims can most effectively be achieved through holding abusers to account and challenging or disrupting their abusive behaviours.

124. This review has, therefore, been thorough in considering information which might highlight opportunities to do this. To this end, the following paragraphs identify Mark's involvement with police and probation services in the years leading up to his relationship with Robyn. The records reveal that Mark is known to at least nine police service areas over 21 years, for incidents including domestic abuse in four areas, violence and weapons in one area, and child abuse in one area. According to information provided by Thames Valley Police, Mark has eight 'non-convictions' recorded on the Police National Computer by different police areas during the period from 2010-2017. These include serious domestic abuse against a previous partner. He has warning markers which include ones for 'Violent' and 'Self-Harm'.

125. In particular, Mark has been reported on at least 15 occasions by partners, ex-partners or concerned parties on behalf of partners in respect of alleged domestic abuse and/or sexual violence and a breach of a non-molestation order[15].

2010:

126. A report of domestic abuse assault against a current partner was recorded as no further action for "evidential reasons".

2013:

127. He is reported for domestic abuse by his ex-partner who he continues to reside with.
128. He is again reported for domestic abuse against the same ex-partner. Both of these incidents are recorded as 'no crime' and filed by police with no further action.

2014:

129. A third domestic abuse incident against the same ex-partner was reported, recorded as 'no crime' and filed with no further action.
130. A fourth incident was reported, recorded and filed as above.
131. Police records in this year also show Mark was subject to a non-molestation order which he breached by visiting the victim in the case and threatening her to withdraw her statement.

---

[13] DASH – a domestic abuse risk checklist, known as the Domestic Abuse Stalking and Harassment, and Honour Based Abuse Risk Indicator Checklist (DASH RIC).

[14] Monckton-Smith, Jane; Siddiqui, Hannana; Haile, Sue and Sandham, Alexandra (2022) *Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing, and intimate partner homicide.* Project Report. University of Cheltenham, Gloucestershire.

[15] A non-molestation order is a civil injunction which a victim of domestic abuse can obtain by applying to the Family Court. These orders are tailored to specific circumstances; typically, they are used to prevent the perpetrator from making contact and/or using abusive behaviour toward the victim, including intimidation, stalking and harassment. It is a criminal offence to breach a non-molestation order.

132. In the same year in a different police area, Mark was reported for alleged rape. Despite extensive attempts, the police were not subsequently able to support the victim to engage with the investigation and the matter was filed with no further action.

2015:

133. A domestic abuse report was made against Mark by an ex-partner who he remained living with; records indicate that upon attending no offences were revealed.
134. A second domestic abuse report was made by the same ex-partner; he was charged but the case was withdrawn (reason not known).
135. A third domestic abuse report was made against Mark by the same ex-partner; no criminal offences were revealed upon police attending.

2016:

136. A female ex-partner reports Mark for alleged rape. No further action is taken due to evidential difficulties.
137. In the same year a third-party anonymous report is made via Crimestoppers over concerns of domestic abuse by Mark against his current partner.
138. Later that year a new partner of Mark makes an application under the Domestic Violence Disclosure Scheme.

2017:

139. In February, Mark was identified to police as a suspect in an adult safeguarding incident where the alleged victim was in a relationship with him and was described as vulnerable due to acute mental health issues. This report refers to him allegedly saying he had threatened an ex-partner until she had taken her own life with poison.
140. In March, Mark is reported for domestic abuse-related 'Threats to Kill' against an ex-partner. He was arrested, but she withdrew her statement, and no further action was taken.
141. In a further domestic abuse-related 'Threats to Kill' incident, a Social Worker reported Mark to police in regard to safeguarding concerns for an ex-partner of Mark who reported receiving around 400 text messages per day with threats. The person in question did not wish to make a complaint to the police so no further action was taken.

2019:

142. Mark was reported as the suspect in an incident of domestic abuse harassment on 29/11/2019 which related to an ex-partner he had been intermittently involved with from 2016 until shortly before the report is made (see entry in core chronology above). She reports that following breaking contact with him, Mark is now allegedly harassing her by continuously trying to contact her through several social media platforms and online Marketplaces. She does not wish to make a statement/complaint, just wants him to stop. There were evidential difficulties (see next paragraph), and no further action is taken.

Analysis

143. We see evidence in the records of behaviours intended to intimidate, or likely to have the effect of intimidating, victims into withdrawing their complaints. This includes a pattern of alleged harassment and allegedly making threats[16]. We know this to be very common in cases of domestic abuse. We are also aware that a significant proportion of domestic abuse and sexual violence allegations cannot be progressed to prosecution due to 'evidential difficulties'[17]. Sometimes this can refer to a victim/survivor withdrawing the complaint (for

[16] The use of threats is a defining feature in the offence of coercively controlling behaviour created by section 76 of the Serious Crime Act 2015. Harassment is understood as a key aspect of domestic abuse and features in the DASH risk indicator checklist. SafeLives guidance for the DASH identifies that stalking and harassment become more significant (in terms of risk) in the context of threats.

[17] The Crown Prosecution Service (CPS) identify attrition rates in criminal justice proceedings for rape offences and domestic abuse offences with some reference 'victim attrition' as an evidential factor, here:

reasons mentioned above) or being assessed as too vulnerable or not able to give evidence for other reasons relating to the impact of the offence or related matters. 'Evidential difficulties' can also refer to the thresholds required by the Crown Prosecution Service (CPS); stringent tests must be passed for a case to be referred to them for consideration.[18]

144. Records provide evidence of some of the indicators of domestic abuse risk (as per the DASH risk indicator checklist). He has been found by police to be in possession of steroids, and Mark has been reported as under the influence of alcohol and class A drugs (cocaine) in some of the alleged offences. Probation records show that Mark was registered with a psychiatrist in 2011 and he is known to have had some contact with mental health services during 2017-2018. Records also show that Mark allegedly engages in stalking and harassing behaviours using online/electronic communications.

145. Some police areas, such as Dorset, demonstrated significant efforts to pursue Mark, albeit these efforts rarely resulted in a criminal justice outcome or other form of intervention focused on him. Hence, despite coming to police notice on several occasions for relevant matters, there have been few opportunities to pursue a conviction or sanction against Mark. He appears to have moved to different areas frequently, compounding the difficulties in deploying any tactics to disrupt his behaviours or bring him before the court. Furthermore, police tactics and responses around this have developed significantly in recent years and may not have been available throughout his history of such behaviour. For example, the Multi-Agency Tasking and Coordination[19] (MATAC) approach is a relatively recent development and is now implemented in many areas including Thames Valley.

CONCLUSIONS AND LESSONS TO BE LEARNT

CONCLUSIONS

146. Robyn and Mark were in a relationship for less than a year and there is minimal documented agency contact during that time. Medical records show that Robyn registered with a GP surgery in Milton Keynes in June 2018. Despite moving to various locations after that time she did not change GP surgery. They contacted her in 2019 to follow up regarding her depression (letters to which she did not reply, perhaps because she did not receive them if she had moved without notifying them); this follow-up had ceased by the end of that year. In early 2020 there were three health interactions, but none represented an opportunity to identify DA or intervene. There does not seem to have been an apparent need for any other service or agency involvement during the period of their relationship, except Thames Valley Police.

147. This review has, therefore, focused largely on the police response to the July 2020 domestic abuse incident which provides the only known opportunity for a statutory agency to engage with Robyn during the relationship. Additionally, the review has paid considerable attention to both of Robyn's pregnancies and post-natal experiences, as well has her mental health issues. Records clearly show that Robyn's mental wellbeing interacts significantly with her experiences of maternity and motherhood and that, despite offers being made on occasion,

https://www.cps.gov.uk/publication/cps-data-summary-quarter-4-2023-2024. More CPS information about the challenges of prosecuting domestic abuse offences here: https://www.cps.gov.uk/domestic-abuse-context-and-challenges.

[18] The 'Threshold Test' and the 'Full Code Test' used by the CPS are explained in Appendix 1 of this report.

[19] MATAC is a multi-agency approach led by police, which identifies and tackles serial perpetrators of domestic abuse. The aim is to reduce reoffending and so increase the safety of victims and survivors.

she accessed little, if any, ongoing support for any of these. Hence there are no records relating to these issues during the period of interest and we cannot be certain what progress Robyn made in her healing from these experiences. We must, then, remain open to the idea that these traumas may have continued to impact her. Therefore, these events and experiences, although some of them fall long before the time she met Mark, must be considered as relevant to her death when we see that this was caused by her suicide.

148. Previous experiences of domestic abuse also interact with these and other life factors to impact on responses to later experiences. Robyn was involved in two domestic abuse incidents in Bedfordshire in 2008. In these incidents she was reported as the perpetrator. However, as discussed earlier, her own injuries, although noted by the police, were not investigated. We are aware of the prevalence of violent resistance by victims of ongoing abuse, although no conclusions can be drawn in this instance. Hence further investigation is warranted in cases with these presentations to identify any pervasive pattern of abuse and who the predominant perpetrator is.

149. By testimonial accounts, the controlling behaviours observed from Mark were intense from early in the relationship and we know such behaviours have a significant and negative impact on mental health. These impacts may be further compounded by early childhood traumas such as experiences in the home and bullying at school. From the information we have received, it seems the four key intersecting themes impacting on Robyn were her experiences of trauma and mental health issues, those of pregnancy and motherhood, those of domestic abuse and coercively controlling behaviour, and her relative isolation both through her itinerant lifestyle and her rural living locations. Lockdown restrictions may have intensified her isolation, and the nature of her accommodation and work,[20] (often being tied together), may have induced financial and housing instability which would also have had an impact. By far the most significant impact on Robyn's life immediately prior to her death, was the abusive behaviour of Mark which we know to have been the latest in a pattern of such behaviour extending back at least 10 years (preceding their relationship). The tactics he appears to have used, including frequent relocation, have confounded opportunities to achieve criminal justice outcomes such as conviction and punishment.

GOOD PRACTICE

150. The Milton Keynes University Hospital independent management review highlights good practice in the identification of potential complications due to Robyn's late presentation with the pregnancy along with her unstable living circumstances. This resulted in her being referred to the Safeguarding Lead Midwife who visited Robyn at her parents' home.

151. Similarly, the South Central Ambulance Service staff were proactive in identifying a safeguarding concern in 2018 and passing that concern on to hospital staff (notwithstanding the gap in making the referral which is already addressed elsewhere in this review).

152. Robyn's employer in Dorset identified concerns and reached out to her family to share these. Information sharing is key to understanding and managing risk, whether amongst professionals or members of the community; this employer showed care and tenacity in communicating in this way.

[20] https://www.womensaid.org.uk/wp-content/uploads/2021/11/Shadow_Pandemic_Report_FINAL.pdf

153. In late July 2020, when Robyn's parents asked her about the renewed relationship, they acknowledged and respected her request for them not to involve themselves and let her know that they were there if she should need them. We know that intervening in a relationship with an abuser can heighten the risk. Specialist support services will advise friends and families of victims to let them know they wish to support without intervening too robustly. We can see this approach was effective as she approached them for their help with her plan to flee to Dorset in August 2020. They engaged with this plan and actively supported her by taking in her pets.

154. The Officer in the case (in relation to the offense reported to Thames Valley Police) demonstrated a victim-focused approach and was sensitive and empathetic to what she was telling them. They also indicated an intent to speak with Mark even once Robyn had stated she wanted to withdraw her statement. This is in line with national (and TVP) strategic thinking about pursuing domestic abuse perpetrators and holding them accountable. We acknowledge that this approach must always be balanced against an assessment of risk of harm to the victim. This may have unwittingly created a situation in which Robyn felt forced to give in to Mark's demands and reconciliation.

LESSONS IDENTIFIED

155. Failing to record contact with domestic abuse victims in the relevant systems at the time means that records may not be accurate and may not adequately reflect the highly dynamic nature of risk in such cases.

156. Safeguarding referrals should always be made by those professionals directly identifying the concern to ensure there is no risk of gaps in reporting concerns through human error in handover processes.

157. The complexity of service provision and referral pathways creates barriers and scope for gaps and human error.

158. Friends and family of domestic abuse victims are often disempowered in being able to help or support their loved one because of the nature and dynamics of the domestic abuse itself.

159. Friends and family of domestic abuse victims are not made aware of advice and support which is available for them in their role as supporters.

160. The issuing of a DVPN, followed up by a DVPO, may have given Robyn space for action and access to specialist services, but was not possible in this case since Mark was not arrested.

161. Maternity and GP records did not document discussions around domestic abuse, therefore we cannot know if anything was asked, what might have been disclosed and what help could have been offered.

162. The officer in the case (TVP) was not aware of their ability to trigger domestic violence disclosure scheme application on Robyn's behalf.

163. Itinerancy presents significant complexities and challenges for professionals who may have a role to support and care for Robyn.

164. Itinerancy presents significant complexities and challenges for professionals who may have a role in apprehending and challenging Mark in respect of his abusive behaviours.

165. Tactics used by perpetrators of domestic abuse make it difficult to tackle their behaviour and secure criminal justice outcomes and increase safety for victims.

166. A victims' decisions about engaging with specialist support (for both mental health and/or domestic abuse) will be based on many intersecting factors and professionals can't know the full picture, especially if their relationship with the person concerned is short-lived. Trauma-informed practice and developing a trusted professional rapport is key to overcoming at least some of these barriers.

RECOMMENDATIONS

Thames Valley Police (TVP)

167. TVP to further explore and develop the use of proactive PNC markers for Domestic Abuse High Risk perpetrators and/or subjects who have a domestic abuse history suitable for disclosure under DVDS (Clare's Law).

168. In light of resourcing challenges within DAIU leading to the lack of ownership or supervisory oversight in relation to medium risk domestic abuse risk management occurrences (RMOs), TVP need to identify which resources will be responsible for medium risk domestic abuse RMO ownership and management. Once these resources have been identified, an audit of these types of RMO should be undertaken in six months to ensure ownership and supervisory reviews are taking place.

169. TVP to give clear direction about whether a Niche RMO should continue to be created by the MASH for cases of medium risk domestic abuse.

170. TVP to determine whether enhanced victim safety planning will be provided for medium risk domestic abuse, and who will undertake this provision.

171. TVP to ensure operational guidance in relation to blocking perpetrators of stalking should be reviewed to ensure it is in line with national guidance and takes account of recommendations from local and national DHRs.

172. TVP to ensure operational guidance reflects the fact that separation or planned separation signifies an escalation in domestic abuse risk.

173. TVP to review operational guidance and ensure it reflects good practice around timeliness of recording contact with domestic abuse victims in the occurrence enquiry log and all other relevant systems.

174. TVP officers/staff to be reminded that where a relevant domestic abuse history is identified, the Clare's Law disclosure application process can be police instigated, even if this is not requested by the person at risk or other interested party.

Buckinghamshire Domestic Abuse Partnership Board

175. Buckinghamshire Domestic Abuse Partnership (BucksDAP) to review and improve the current response and support available to those affected by domestic abuse in rural communities, ensuring they receive the support they need to overcome the challenges they face.

176. BucksDAP to improve the response and support available to people with itinerant lifestyles.

177. BucksDAP and relevant providers should work to ensure awareness and clarity about domestic abuse referral pathways amongst frontline services.

178. BucksDAP and relevant providers should work to reduce barriers and maximise accessibility to specialist domestic abuse services.

179. Buckinghamshire Council, BucksDAP and specialist domestic abuse advice and support services should ensure these services are promoted and available for friends and family members of victims and survivors.

Review Chair

180. Awareness should be raised at a national level about concerns regarding the potential for gaps in responding effectively to victims and survivors of domestic abuse where thresholds for statutory intervention are not met.

Safer Buckinghamshire Board members

181. All safeguarding settings to review and ensure there is an effective response to domestic abuse where the statutory threshold is not met.

182. All provider agencies should demonstrate how their audit processes identify the activity relating to asking service users about domestic abuse, mental health and suicidality, and how these meet relevant practice guidelines. They should ensure that any training reflects this requirement.

183. All provider agencies should review their training requirements to ensure this includes opportunities for staff to attend mental health first aid and suicide prevention first aid training.

South Central Ambulance Service (SCAS)

184. SCAS should ensure that current safeguarding training emphasises:

- The consideration, awareness and identification of domestic abuse and appropriate responses,
- The need for professional curiosity around domestic abuse and what this looks like,
- The need for professional consideration of the extrinsic factors which may impact on safeguarding,
- The importance of information sharing and the need for staff to make safeguarding referrals in line with local and national policy.

Buckinghamshire Council (Public Health Team)

185. Ensure the Making Every Contact Count approach and training includes reference to mental health and suicide.

186. Review the multi-agency suicide prevention action plan to ensure it aligns with the new national Suicide Prevention strategy for England 2023 – 2028 and incorporates recommendations from DSRs locally and nationally.

187. Ensure there is an annual deep dive on DSRs as part of the multi-agency suicide prevention meeting and that specialist domestic abuse services are represented.

188. Review and implement actions to improve quality of, and identify potential efficiencies for, local data to monitor suicide in Buckinghamshire: Real Time Surveillance System (RTSS) work with Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) and Thames Valley colleagues to further develop the regional RTSS in line with national good practice. Monitor and contribute to the new early warning National Near to Real Time Suspected Suicide Surveillance System (NRTSSS) providing updates to the Buckinghamshire multi-agency suicide prevention group on a quarterly basis for review.

Oxford And Milton Keynes University Hospitals

189. OUH and MKUH should ensure maternity staff follow the NICE Antenatal Guidance (2021) in relation to domestic abuse.

Adult and Children's Social Care (Buckinghamshire, Milton Keynes and Bedfordshire)

190. Adult and Children's Social Care should ensure routine questions about domestic abuse are asked and recorded.

191. Domestic abuse knowledge should be refreshed with all Social Care staff every 3 years.

GLOSSARY

Child in need – Under section 17 of the Children Act 1989, Children's Social Care is obliged to provide appropriate support in enabling families to safeguard and promote the child's welfare where they are assessed as being a 'child in need' under that section of the Act.

DAIU – the Domestic Abuse Investigation Unit is a specialist unit within Thames Valley Police who risk-manage and investigate high-risk domestic abuse cases.

DASH – a domestic abuse risk checklist, known as the Domestic Abuse Stalking and Harassment, and Honour Based Abuse Risk Indicator Checklist (DASH RIC) - https://www.dashrisMarkhecklist.co.uk/.

DOM5 – a version of the DASH (see above), adapted for use by Thames Valley Police.

DVPN – Domestic Violence Protection Notices (DVPN) and Domestic Violence Protection Orders (DVPO, see below) aim to provide victims with immediate protection following an incident of domestic violence and gives them time to consider what to do next. Best practice identifies that as part of this process victims should be contacted by local specialist services providing advice and support. A DVPN is served by the police on perpetrators of domestic abuse and provides emergency protection for victims. It must be presented to a magistrates' court for approval within 48 hours of it being served.

DVPO – Domestic Violence Protection Orders are granted by the magistrates' court. Once a DVPN (see above) has been served by the police it must be presented to a magistrates' court within 48 hours. If the magistrates agree, the prohibitions stated within the notice can continue for between 14 to 28 days in the form of a DVPO.

MASH – the Multi-Agency Safeguarding Hub is a virtual team of specialists from statutory agencies who receive referrals for safeguarding concerns from the public and other professionals. They coordinate appropriate responses to these in line with statutory guidance.

MATAC – Multi-Agency Tasking and Coordination is a multi-agency approach led by police, which identifies and tackles serial perpetrators of domestic abuse. The aim is to reduce reoffending and so increase the safety of victims and survivors.

No-crime – a term used by police when recording incidents; an incident is labelled in this way when the incident, so far as can be determined by the police, has not crossed the threshold of being a criminal offence.

No further action – a term used by police when recording the outcome of their involvement in an incident that has been reported to them; a case is labelled in this way when police are unable to refer the case to the Crown Prosecution service to take it to court.

OEL – an occurrence enquiry log is a police term referring to entries made in the log against a 'risk management occurrence', i.e. an incident they are dealing with.

Risk (domestic abuse) – risk indicated through the DASH is categorised as either: high (evidence of identifiable indicators of risk of serious harm, and the incident could happen at any time and the impact would be serious), medium (evidence of identifiable indicators of risk of harm; the offender could cause harm but is not likely to do so unless there is a change in circumstances), or standard (no evidence of significant current indicators of harm).

Risk management occurrence – a police term used to describe the way they identify and log an incident they are dealing with when it requires active risk management activity, e.g., in cases of domestic abuse or other violent crimes.

Safeguarding – the process of acting to protect a child or a vulnerable adult from harm; there are statutory requirements for professionals to respond to safeguarding concerns.

Safety planning – a formal, written approach to identifying specific risks and the ways in which the victim of domestic abuse can manage these more safely.

APPENDIX 1

Crown Prosecution Service – Tests for Prosecuting (Information provided by Thames Valley Police)

In order to refer matters to the Crown Prosecution Services (CPS), either the Threshold Test or Full Code Test must be applied. The Threshold Test is intended to apply to a very limited range of cases where the Full Code Test cannot be met but the overall seriousness or circumstances of the case justify the making of an immediate charging decision, and there are substantial grounds to object to bail.

There are five conditions to be met:

1. There are reasonable grounds to suspect that the person to be charged has committed the offence.
2. Further evidence can be obtained to provide a realistic prospect of conviction.
3. The seriousness or the circumstances of the case justifies the making of an immediate charging decision.
4. There are continuing substantial grounds to object to bail in accordance with the Bail Act 1976 and in all the circumstances of the case it is proper to do so.
5. It is in the public interest to charge the suspect.

If any of the five conditions are not met, the Threshold Test cannot be applied and the suspect cannot be charged. If there is no prospect of the case ever meeting the evidential stage of the Full Code Test, it must be the subject of no further action.

The Full Code Test has two stages, the Evidential stage and the Public Interest stage.

The Evidential Stage – sufficient evidence to provide a realistic prospect of conviction. This means than an objective, impartial and reasonable jury or bench of magistrates or judge hearing a case alone, is more likely than not to convict the defendant of the charge alleged. A case which does not pass the evidential stage must not proceed, no matter how serious or sensitive it may be.

The Public Interest Stage – Is a prosecution in the public interest? The following are relevant points:

- How serious is the offence – more likely to proceed the more serious the offence
- What is the level of culpability of the suspect – more likely the more culpable. This includes level of involvement, whether the offending was planned, if the suspect gained from the offence, likelihood of escalation or repeat, pre-cons.
- Circumstances of the victim – the more vulnerable the victim is, the more likely prosecution is required.
- Suspect's age and maturity at time of offence – under 18 less likely

- Impact on community – greater impact more likely
- Is prosecution proportionate response – cost is considered
- Do information sources need protecting – if so less likely

The Full Code Test should be applied:

a) When all outstanding reasonable lines of enquiry have been pursued; or
b) Prior to the investigation being completed, if the prosecutor is satisfied that any further evidence or material is unlikely to affect the application of the Full Code Test, whether in favour of or against a prosecution.

If neither the Threshold Test or Full Code Test can be met then the matter cannot be referred to the CPS to request a charging decision.

APPENDIX 2

Identified parties in this action plan:

'All provider agencies': refers to all those agencies otherwise named as lead agencies elsewhere in this action plan (namely, Thames Valley Police, South Central Ambulance Service, Social Care in Buckinghamshire and Milton Keynes, Public Health in Buckinghamshire and Milton Keynes, Oxford University Hospitals, Milton Keynes University Hospitals).

'Relevant providers': refers to all organisations who are responsible for delivering front-line services, including statutory and non-statutory support services and the voluntary and charity sector (e.g. services offering support around housing and homelessness, crime/victimisation, mental health, complex needs, bereavement, etc.).

'Specialist domestic abuse services': refers to all services commissioned, or grant/charity funded to deliver specific and specialised support around domestic abuse including the delivery of training and awareness.

This action plan is being continually being monitored and updated by the Safer Bucks Board.

Recommendation	**Scope i.e. local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date**	**Completion Date**	**Outcome**
What is the over-arching recommendation?	*Local, Regional or National*	*How exactly is the relevant agency going to make this recommendation happen? What actions need to occur?*		*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?*
Bucks DAP to review and improve the current response and support available to those affected by domestic abuse in rural communities, ensuring they receive the support they need to	Local	Buckinghamshire Council should lead on the development of a multi-agency action plan on domestic abuse in rural areas. The aim of this plan should be to identify and address the specific challenges and barriers for victims and survivors of	Bucks DAP	This will be delivered as part of the DA & VAWG Strategy 2024-27 and is included in the Delivery Plan for year 2 Oct 25-26	2025/26	-	Agencies will have identified and implemented effective practices, including multi-agency working, to improve the

overcome the challenges they face.		domestic abuse living in rural communities in seeking and receiving effective domestic abuse support.					awareness of and accessibility of domestic abuse services for those living in rural areas.
Bucks DAP to improve the response and support available to people with itinerant lifestyles.		Buckinghamshire Council should lead on the development of a multi-agency action plan on domestic abuse impacting people with itinerant lifestyles, including agricultural workers, and Gypsy, Roma and Traveller communities. The aim of this plan should be to identify and address the specific challenges and barriers for victims and survivors of domestic abuse with itinerant lifestyles in seeking and receiving effective domestic abuse support.	Bucks DAP	This will be delivered as part of the DA & VAWG Strategy 2024-27 and is included in the Delivery Plan for year 2 Oct 25-26	2025/26		Agencies will have identified and implemented effective practices, including multi-agency working, to improve the awareness of and accessibility of domestic abuse services for those with itinerant lifestyles.
Buckinghamshire Council, Buckinghamshire Domestic Abuse Partnership (Bucks DAP) and relevant providers should work to ensure awareness and clarity about domestic abuse referral pathways amongst frontline services.	Local	Promote BDAP which has the referral pathways on the website. Ensure all Bucks DA Champions are aware how to access pathways. Ask other providers to promote on their websites. Send the referral pathways document to schools and housing providers across Bucks. Workshop on referral pathways with potential for victim journey to be held and promoted.	Bucks DAP	Referral pathways are promoted on our Buckinghamshire Domestic Abuse Partnership website (Bucks DAP). They are also available on the Reducing the Risk website which is for all Bucks DA Champions. Pathways are covered in DA Champions training. Referral pathways document has also been sent to all educational settings and housing providers in Bucks. Workshop on referral pathways with potential for victim journey to be held and promoted at White Ribbon Day conference. (Dec 24). June 25 update	March 24 Dec 24	March 24	Staff in all agencies know how to and are able to access referral pathways so that residents access the most appropriate service at the first opportunity.

				There will be specific multiagency training in the 2025/26 training catalogue around this (power hours). Also, we are running a series of multiagency referral pathway workshops, and a T&FG has been convening to plan the schedule for these and what they will include. This work will be delivered in the 25/26 financial year.	2025/26		
Buckinghamshire Council, Bucks DAP and relevant providers should work to reduce barriers and maximise accessibility to specialist domestic abuse services.	Local	As part of the DA Strategy the Bucks Domestic Abuse Partnership will set up a 'Tell us Once' network which will enable all organisations to work together and share information. Work towards the Standing Tall model of a single front door for support.	Bucks DAP	This will be delivered as part of the DA & VAWG Strategy 2024-27 and is included in the Delivery Plan	2025/26		Residents will only share their story once and have access to many other support services according to their own expressed needs.
Buckinghamshire Council, Bucks DAP and specialist domestic abuse advice and support services should ensure these services are promoted and available for friends and family members of victims and survivors.	Local/combine	Ensure that all BC commissioned DA services provide support for friends and family members of victims and survivors. Ensure that all services raise awareness that they are available for friends and family. Specific campaigns within the Bucks DAP Strategy.	Bucks DAP	The Bucks DAP website has a section devoted to friends and family. This website is promoted using posters, flyers and table talkers which are used by different organisations across the county.	This has been in place since December 2023	December 2023	Friends and family members of victims and survivors of domestic abuse know about support services available to them across Bucks.
Awareness should be raised at a national level about concerns regarding the potential for gaps in responding effectively to victims and survivors of domestic abuse where	National	The review Chair should write to relevant public figures and/or public offices to raise the concerns about the effectiveness of responses to domestic abuse in a safeguarding context when the	Review Chair		December 2024	February 2025	Letter sent to Yvette Cooper,Home secretary and copied to Jess Philips Parl

thresholds for statutory intervention are not met.		threshold for statutory intervention is not met.					Under Sec of State, Nicole Jacobs DAC, Chris Philp Shadow Home Sec. Responses received that this has been flagged and will hopefully be covered in their new strategy later in the yea Relevant public figures, with authority and mandate to act in such matters, are aware of the impacts of gaps in responses to victim-survivors of domestic abuse when they do not meet criteria for statutory safeguarding interventions.

All safeguarding settings to review and ensure there is an effective response to domestic abuse where the statutory threshold is not met.	Local	Buckinghamshire Council should produce step-by-step guidance for frontline ASC, CSC and AMHT staff, detailing best practice for responding to domestic abuse and identifying the referral pathways.	Safer Buckinghamshire Board members	The text has been written (March 24) and delivered as part of the safeguarding handbook. Handbook launched October 24	July 24	October 2024	All agencies will have reviewed and updated their safeguarding policies to identify routes/options for appropriate support for domestic abuse victims/survivors when statutory safeguarding intervention is not required. Victims and survivors of domestic abuse who have been referred into safeguarding settings but are not brought into statutory services are effectively supported to access relevant specialist domestic abuse support.
All provider agencies should demonstrate how their audit processes identify the activity relating to asking service users about domestic abuse, mental health and	National and Local	Each agency has a dip check process dictated by number of cases they have.	Safer Bucks Board members to oversee	Adult Social Care: have a Quality Assurance Framework which supports us to monitor practice across the Social Work function. This includes regular case reviews and audits.	Apr 2024 (ASC)	Apr 2024 (ASC)	There are regular case reviews, audits or dip checks to ensure the relevant practice is being implemented and

suicidality, and how these meet relevant practice guidelines. They should ensure that any training reflects this requirement.				Children's Social Care: Children Social Care's Quality Assurance Framework embeds DA learning through audit activity. The case file audit tool focusses on specific areas linked to DA and assists to inform where strengths of practice are, and where practice needs to be strengthened further. Buckinghamshire Healthcare Trust: regularly undertake audits. These include the recording of asking questions relating to domestic abuse, most notable via maternity services, health visiting services, and in ED, where indicated. TVP: The introduction of the CMF (crime management framework) means that at initial point of investigation set questions are asked of officers in relation to MH and suicide. Risk and safeguarding is a theme throughout this which is continued at Supervisory reviews at various points throughout the investigation life. So that oversight is there without the need for specific audits. Referrals are also to be considered. Questions in relation to this are also covered in the DOM5 which is signed off by a supervisor. GPs/ICB: [response required?]	April 23 (TVP)	April 23 (TVP)	this is managed within a performance management process.

				OUH: The Trust undertakes audits to ensure compliance with domestic abuse pathway and a specific audit in maternity 2023 identified an improvement with compliance of routine enquiries for DA. Recognising DA is included in mandatory safeguarding training. The emergency department routinely ask safety questions when patient attend to ensure opportunities to intervene are not missed. Maternity ask Generalised anxiety disorder questions of pregnant women and birthing people, and the Whooley (depression screening questions). This was audited and due for reporting. **Milton Keynes University Hospital (MKUH)** The introduction of a compulsory professional enquiry question for all adult patients on presentation to the Hospital will support staff in determining if a person is subject to domestic abuse and if they feel safe at home. By making this question a 'pop up' and not allowing the staff to progress the assessment pathway until they have answered the enquiry will make this standard assessment protocol. It also allows staff who feel anxiety asking questions related to Domestic abuse to inform patients it is standard practice and a must ask. This element of the electronic record will allow audit to understand compliance and			

				support feedback to users. Where there is reduced compliance targeted support will be directed. In addition to this we have recently updated our face-to-face training to include increased focus on Domestic abuse and the impact on individuals and their relatives – 'Think Family' is our approach to increase staff understanding. Compliance with training targets is measured and reported at Board and departmental level.			
All provider agencies should review their training requirements to ensure this includes opportunities for staff to attend mental health first aid and suicide prevention first aid training.	Local	Review current training requirements. Update organisational workforce plan to include opportunities for mental health first aid and suicide prevention first aid. Implement regular monitoring process for training compliance. (Bucks Council) BDAP promote suicide prevention training on our website. We are also going to join the suicide prevention sub group.	Safer Buckinghamshire Board to oversee	**Public Health:** Audit of training requirements completed. training requirements enacted. Regular monitoring of take up. **Bucks Domestic Abuse Partnership:** promote suicide prevention training on our website. **Adult Social Care/ Children's Social Care:** Opportunities for all social care staff to attend mental health and suicide training are promoted via several different routes /platforms at Buckinghamshire Council. **Buckinghamshire Healthcare Trust:** Buckinghamshire Healthcare Trust regularly undertake audits. These include the recording of asking questions relating to domestic abuse, most notable via maternity services, health visiting services, and in ED, where indicated.	Dec 2024	complete	Public Health team promote opportunities for all public, community and VCSE agencies to attend Suicide First Aid training. Staff in all agencies are able to access, and are encouraged to complete, mental health first aid and suicide prevention first aid training, and to update this training at regular intervals.

				TVP: – The introduction of the CMF (crime management framework) means that at initial point of investigation set questions are asked of officers in relation to MH and suicide. Risk and safeguarding is a theme throughout this which is continued at Supervisory reviews at various points throughout the investigation life. So that oversight is there without the need for specific audits. Referrals are also to be considered. Questions in relation to this are also covered in the DOM5 which is signed off by a supervisor. **Milton Keynes University Hospital (MKUH)** Safeguarding training is mandatory for all staff working at the Hospital, a new training package 'Think Family' has recently launched that has altered safeguarding training with updated concepts and practical scenarios which includes recognition of mental health and suicide awareness. Compliance is measured across the Trust and reported at divisional and departmental level with expectation and attendance targets mandated by the Board. **GPs/ICB:** ICB-This is not mandatory for GP's to do this training, but modules are			

				available on the adult safeguarding training hub , that any GP can access, and we do talk about cases that relate to mental health and suicide within the PSLN and discuss learning points. GP's with extended roles may have done this training and will disseminate the learning from through the practice, for example as I am named GP for safeguarding adults - I have done both of these courses and shared knowledge with my practice. **OUH:** Recognising DA is included in mandatory safeguarding training. Training was reviewed May 2024 and includes updated learning from partnership reviews and included DA. There is a psychological medicine service embedded in the Trust and commissioned emergency department psychological medicine services to support patients. They are specially trained in recognising risk of suicide and management. There is not specific Trust wide suicide prevention training available to all staff.			

				There is a staff wellbeing service to support. This is to access support for themselves or others by special trained staff. Supervision is available to staff on a case by case basis. Pathways are in place to ensure information is shared between departments and safeguarding to ensure patient are supported during admissions and attendance in ED. There is a Hospital IDVA project in place to support patients.			
TVP to further explore and develop the use of proactive PNC markers for Domestic Abuse High Risk perpetrators and/or subjects who have a domestic abuse history suitable for disclosure under DVDS (Clare's Law).	National	Through the NPCC working group this is to be explored and if authorised then TVP to adopt	Thames Valley Police	Markers for domestic abuse are routinely and systematically entered on PNC for all subjects who have a domestic abuse history suitable for disclosure under the DVDS (Clare's Law), directing enquirers to relevant information on PND.		Oct 2022	This is now business as usual process within TVP. Operational guidance updated for officers.

In light of resourcing challenges within DAIU leading to the lack of ownership or supervisory oversight in relation to medium risk domestic abuse RMOs, TVP need to identify which resources will be responsible for medium risk domestic abuse RMO ownership and management. Once these resources have been identified, an audit of these types of RMO should be undertaken in six months to ensure ownership and supervisory reviews are taking place.	Local	Review RMO process	Thames Valley Police **Governance and Service Improvement Department**	Await findings from review	Dec 2024 now December 2025		RMO's are being reviewed in force to ensure that they are being utilised correctly. In the interim there is clear operational guidance in TVP identifying the ownership of domestic abuse risk management occurrences and what the core requirements of such risk management involve. Such guidance is disseminated to all relevant officers and civilian staff and includes requirements for recording, interaction and tasking by other TVP officers or staff.

TVP to give clear direction about whether a Niche RMO should continue to be created by the MASH for cases of medium risk domestic abuse.			Thames Valley Police		Decembe r 2025		As above.
TVP to determine whether enhanced victim safety planning will be provided for medium risk domestic abuse, and who will undertake this provision.	Local	Review whether enhanced victim safety planning will be provided.	Thames Valley Police/ OPCC	Testing phase to be completed and then roll out to be actioned.	Spring 2025 Now Aug 25		There is a clear protocol in TVP identifying how victims and survivors subjected to domestic abuse which is assessed as medium risk will be offered safety planning. However on-going work is being explored as currently victims need to provide consent when they are referred to victim first where further safety planning takes place. Through work in the OPCC office it is being explored

							that an automated referral to victim first occurs and the victim would need to opt out of this. This will potentially be in place by latter half 2024/early part of 2025. This will allow all victims to be offered support and ensure that as a force we have compliance with the victims and prisoners bill. A number of measures will be in place to ensure that automatic referral does not put victims at further risk and these will be tested before role out. **Feb 25 Update** We will be moving to automatic referral of victims from TVP into the

							Victims First Hub (VFH) in June this year.
TVP to ensure operational guidance in relation to blocking perpetrators of stalking should be reviewed to ensure it is in line with national guidance and takes account of recommendations from local and national DHRs.	Local	Stalking lead DCI level and Stalking DS have reviewed this practice and operational guidance to be amended as per national guidance.	Thames Valley Police **Emily**	Internal communications and training updates to be provided so that change is embedded. This has been done internally "In the know". Risk assessment training to frontline officers incorporates this as well as revised new recruit training. Stalking SPOC's and any departmental delivery sessions provided are updated to that effect.	Dec 2023	Dec 2023	Officers are now advising victims in relation to blocking perpetrators in line with national guidance. Operational guidance reflects this.
TVP to ensure operational guidance reflects the fact that separation or planned separation signifies an escalation in domestic abuse risk.	Local	To speak with G&SI department that operational guidance reflects this. Also to ensure that this is covered in risk assessment training that is due to be rolled out to front line officers on teams in action days.	Thames Valley Police **Emily**	Liaison has taken place and operation guidance updated to that effect. Risk assessment training has now been written by an external provider commissioned by TVP. 2-hour training input will be delivered, and this aspect is discussed within the training. This has also been included in foundation training and within the DA specialist course.	August 2024	August 2024	Reviews and audits of DOM5's reflect this guidance and ensure it is implemented. Training is still being delivered to officers and will be completed by August 2024. Training on other courses will continue to be delivered. The training will enhance officers' knowledge

							around risk escalation.
TVP to review operational guidance and ensure it reflects good practice around timeliness of recording contact with domestic abuse victims in the occurrence enquiry log and all other relevant systems.	National	Introduction of the victim code to be implemented in TVP. This is for all victims of crime. This will ensure that victims of DA timely updated	Thames Valley Police **Emily**	Training packages to be completed in both e-learning and face- to face training. Packages have devised and all staff to review. Performance framework to be implement so monitoring of compliance can be done. CMF framework to be implement which is a template that is completed by all supervisors at various points within an investigation. Sgt/Inspector review every 28 days for Domestic investigation. C/Inspector – 90 days and Supt 120days. Within that framework and template is specific questions regarding victim contact.	2022 April 2023	2022 April 2023	There is operational guidance in TVP which identifies clear timescales for recording contact with victims and survivors of domestic abuse in Niche and all relevant systems. Audits, reviews and dip-checks are undertaken to ensure this is implemented. This is now part of daily business. Compliance with completing the CMF template is addressed through

							department and team health checks that occur every 10 weeks. This is also addressed through Force Performance Group which is chaired by DCC monthly.
TVP officers/staff to be reminded that where a relevant domestic abuse history is identified, the Clare's Law disclosure application process can be police instigated, even if this is not requested by the person at risk or other interested party.	Local	To ensure that communication is delivered to officers that DVDS can be actioned by officers and that they are reminded of this within various training packages	Thames Valley Police **Emily**	Risk assessment training has been commissioned by TVP to be written by an external provider. Within that training package there is guidance about DVDS and that officers can process a right to know. This will be delivered to officers as part of a 2-hour input. Communications sent out in "In the know" (internal publication) updating officers on changes to DVDS that operational guidance has been updated to reflect the DVDS statutory guidance by HM government.	Dec 2023 October 2023	August2024 October 2023	The training package has been written and is currently being delivered to officers. It is approximately halfway through delivery. The target audience is ICR PC's/Neighbourhood/Sgts and Inspectors. This will be completed in August 2024. There is operational guidance in TVP which identifies the duty of officers under the 'right to know' aspect of the DVDS and

							identifies the procedure for doing so. Audits of DVDS disclosures identify the numbers and proportions of disclosures which are made under the 'right to know' route. There has been a steady increase. DVDS numbers are monitored internally.
SCAS should ensure that current safeguarding training emphasises: • The consideration, awareness and identification of domestic abuse and appropriate responses, • The need for professional curiosity around domestic abuse and what this looks like, • The need for professional consideration of the extrinsic factors which may impact on safeguarding, • The importance of information sharing and	Local	Domestic Abuse training content to be included in the safeguarding induction delivered all staff joining SCAS. Further training on domestic abuse to be added to the safeguarding level 2 & 3 packages.	South Central Ambulance Service (Safeguarding Team)	SCAS recognise the importance of awareness of domestic abuse and have responded by including Domestic Abuse training content in the safeguarding induction delivered all staff joining SCAS. SCAS have also added further training which is delivered in the safeguarding level 2 & 3 packages.	April 23	April 23	All SCAS staff receive safeguarding induction training which includes relevant content on domestic abuse. Safeguarding levels 2 and 3 training also includes relevant content on domestic abuse.

the need for staff to make safeguarding referrals in line with local and national policy.							
Ensure the Making Every Contact Count approach and training includes reference to mental health and suicide.	Local	Review current training content of MECC. Review opportunity to include specific reference to suicide prevention.	Buckinghamshire Council, Public Health	Training content review completed. Discussions with MECC lead about references to suicide prevention underway.	September 2024	December 2024	MECC training approach includes reference to mental health and suicide prevention.
Review the multi-agency suicide prevention action plan to ensure it aligns with the new national Suicide Prevention strategy for England 2023 – 2028 and incorporates recommendations from DSRs locally and nationally.	Local	Multi agency review of suicide prevention action plan in line with national recommendations.	Buckinghamshire Council, Public Health	Action plan review completed. Publication of action plan.	April 2024	April 24	Multi agency actions and any links to domestic abuse are identified and monitored to support suicide prevention.

Ensure there is an annual deep dive on DSRs as part of the multi-agency suicide prevention meeting and that specialist domestic abuse services are represented.	local	Identify annual agenda item focusing on recommendations and key learning from DSRs.	Buckingham shire Council, Public Health	Annual agenda item confirmed.	April 2024	April 2024	Any identified key learning and recommendation s to be incorporated into review on multi agency suicide action plan.
Review and implement actions to improve quality of, and identify potential efficiencies for, local data to monitor suicide in Buckinghamshire.	Local	Public Health: Audit current processes for suicide data collection. Agree with key partners a standardised data collection tool, to include information about domestic abuse where relevant.	Buckingham shire Council, Public Health	Real Time Surveillance System (RTSS) work with Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) and Thames Valley colleagues to further develop the regional RTSS in line with national good practice. Monitor and contribute to the new early warning National Near to Real Time Suspected Suicide Surveillance System (NRTSSS) providing updates to the Buckinghamshire multi-agency suicide prevention group on a quarterly basis for review.	Dec 2024	Dec 2024	The multi-agency suicide prevention panel and member agencies have access to standardised, comparable data with which to understand and plan for suicide prevention, especially as it relates to domestic abuse.
OUH and MKUH should ensure maternity staff follow the NICE Antenatal Guidance (2021) in relation to domestic abuse.	Local	OUH have undertaken audit on NICE guidance in 2021 and repeated Aug 2022 following the DA maternity pathway update.	OUH/MKHU	Audit undertaken x 2 to review NICE guidance compliance. MKUH-Update ANC care pathway guidance updated 10/2023. Auto text set on eCare set up for set every antenatal appointment to ensure RI. – completed 10/2023.		Sept 2022 OUH MKUH	The repeat audit showed that the DA questions are being asked when safe to do so at booking (or later if not safe to do at booking) and showed an improvement in documentation. This is being repeated 3 yearly.

						Oct 23	Over 2022-2023 mandatory safeguarding training was delivered for all midwives and maternity support workers. MKUH- compliant with NICE guidance – EPR captures data.
Adult and Children's Social Care should ensure routine questions about domestic abuse are asked and recorded.	Local (in all affected areas; Beds, MK, Bucks)	Adult Social Care have a robust training, assessment and quality assurance measures in place to ensure that domestic abuse is a routine question asked by staff. Adult Social Care have embedded 2 specialist domestic abuse workers into their Safeguarding function and have mandatory domestic abuse training for all staff. Bucks Children's SC-Where DA is identified / suspected we would do this within our assessment process – and would be recorded within that in the context of impact of parenting on child. we would also do this as part of	Bucks Adult Social Care Bucks CSC	Mandatory training in place 2 x specialist domestic abuse workers embedded within the team. Quality Assurance Framework in place from 2024-2026. Bucks CSC Where DA is identified / suspected we would do this within our assessment process – and would be recorded within that in the context of impact of parenting on child. we would also do this as part of parenting assessments where relevant and also have guidance to support staff in questions etc.	Apr 2024 Already in place	Apr 2024	Procedures and policies state the need to routinely ask and record questions about domestic abuse in line with relevant practice standards and guidelines. There are regular case reviews, audits or dip checks to ensure this practice is being implemented and professional development identified where needed.

		parenting assessments where relevant and also have guidance to support staff in questions etc.	Beds CSC Beds ASC	The Practice Development Team (PDT) provide Learning and &Development sessions on DA yearly. Other sessions that include DA are Parental Mental Health and Trio of Vulnerabilities. The PDT carry out testing the impact of DA training attended with selection of 5 practitioners, discussions are reflective of the learning and evidence of this in case records. New referrals to Children's Social Care are managed by the Integrated Front Door who are trained in using the CAADA-DASH Risk Assessment and supported by our Domestic Abuse co-ordinator. Nearly a third of all of our contacts involved domestic abuse. Each contact is screened for risk issues including domestic abuse by a qualified Social Worker. Workers in assessment and longer term teams are also trained . Like our colleagues in Adult Social Care we have access to the IDVA. In Bedford Adult Services any concerns of DA whether the person has care and support			

				needs or not will be considered under safeguarding with appropriate signposting if required. Bedford Adult social care practitioner's have received training on Professional Curiosity and Risk assessment as part of any assessment process. We have an IDVA that sits between Adult Social Care and Housing who is available to offer support and advice to multi disciplinary care management teams. The Adult Safeguarding team have representation at MARAC panel. The Head of Safeguarding sits on the PAN Bedfordshire Marac Governance Group and Bedford Borough Domestic Abuse Local Partnership Board.			

			MK CSC-	MK Ad/ Children All Social Workers across adults and children's services are aware of the need to question clients where there is a likelihood of DA and or where DA is the key risk indicator. Staff are aware of the DASH RIC tool and what services to refer into via MKACT. There is a DA strategic board as well as a DA operational group that has representation from Children's and Adults.			
Domestic abuse knowledge should be refreshed with all Social Care staff every 3 years.	Local (in all affected areas; Beds, MK, Bucks)	Domestic Abuse Training is mandatory for all staff. Staff must complete their Safeguarding training once every 3 years and within this there is a dedicated module on Domestic Abuse.	Bucks Adult Social Care Bucks CSC Beds CSC	Mandatory training in place. Bucks CSC-DA Training is not mandatory. Domestic abuse training is refreshed with all staff every 3 years but there is also continuous training and support available to staff in various forms. Bucks Training Catalogue. PD Team have run L&D and Journal Club sessions on DA. There are a number of DA eLearning modules on the Learning Hub: There are many articles on Community Care Inform. Domestic abuse training is required within Children's	Apr 2024	Apr 2024	All social care staff access domestic abuse training every three years. CPD records and reviews track and monitor training accessed by staff, so that audits can demonstrate this requirement is being met.

				services and is renewed regularly. In 2025 we will are training staff in the Safe and Together model which will become our mandatory training and is renewable			
			MK CSC	MK Adults and Children's social care Social Workers in Milton Keynes must attend DA refresher training on a yearly basis. This is in place and is regularly communicated to all staff.			
			Beds ASC	Domestic abuse training E-Learning and some face to face training is a part of Adult Social Care training schedule and is mandatory. At present it is not a requirement to refresh these every 3 years, we will review this in our training needs analysis development plan.			