

Safer Somerset Partnership

Multi- agency Domestic Abuse Death Review

Overview Report

Into the death of Mr D (pseudonym) in April 2017

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Independent Domestic Homicide
Review Chair and Report Author

Report Completed: 31st July 2018

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1. Preface

- 1.1 Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-
- a) A person to whom she was related or with whom she was or had been in an intimate personal relationship or
 - b) A member of the same household as herself; held with a view to identifying the lessons to be learnt from the death.
- 1.2 Throughout the report the term 'domestic abuse' is used in reference to 'domestic violence' as this is the term which has been adopted by the Safer Somerset Partnership.
- 1.3 The purpose of a DHR is to:
- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and agencies work individually and together to safeguard victims;
 - Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
 - Apply those lessons to service response, including changes to policies and procedures as appropriate, and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- 1.4 This death was not caused by a homicide but a suicide. However, following the revised DHR guidance published in December 2016 it is now mandatory for a statutory review to be undertaken where an individual has committed suicide and it is believed this could have been connected to domestic abuse. This review examines the circumstances surrounding the death of Mr D (pseudonym) in the Taunton Deane area in April 2017. The principles underpinning the review process have been followed in accordance with the Home Office Multi-Agency Statutory Guidance on the Conduct of Domestic Homicide Reviews- Revised Version-December 2016.
- 1.5 The Independent Chair and the DHR Panel members offer their deepest sympathy and condolences to Mr D's family. The Chair would also like to thank the Review Panel who have contributed to the deliberations of the Review, for their time, honesty, transparency and cooperation.

- 1.6 The Chair of the Panel possesses the qualifications and experience required of an Independent DHR Chair, as set out in section 5.10 of the Home Office Multi- Agency Statutory Guidance. She is not associated with any of the agencies involved in the Review nor has she had any dealings with either Mr D or Miss E and she is totally independent.

2. Domestic Homicide Review Panel

- Faye Kamara LLB, MSc- Independent Chair
- Suzanne Harris, Somerset County Council
- Melanie Thomson, Formerly known as Knightstone, now known as Live West from 2018 (SIDAS- Somerset Integrated Domestic Abuse Service)
- Joanna Mines, Avon and Somerset Constabulary
- Punita Bassi, Avon and Somerset Constabulary (IMR Author)
- Julia Burrows, Somerset Partnership NHS Foundation Trust (SomPar)
- Andrew Tresidder, Somerset Clinical Commissioning Group
- Ben Judd, Somerset Drug and Alcohol Service
- Alex Chapman, Somerset Drug and Alcohol Service
- Darryl Northover, Taunton Association for the Homeless
- Charlotte Coker, Community Rehabilitation Company (Probation)
- Duncan Marrow, Taunton and Somerset NHS Foundation Trust

3. Introduction

- 3.1. This review examines the circumstances surrounding the death of Mr D (pseudonym) who was 36 years of age and had lived in Taunton, Somerset for many years but at the time of his death he was of no fixed abode.
- 3.2 Mr D was a bisexual gentleman who had had relationships with men in the early 2000s however more latterly with a female named Miss E. He was an opiate drug user and had been for a number of years. He was known to the Somerset Drug and Alcohol Service and had been released from Her Majesty's Prison on license in January 2016.
- 3.3 Mr D and Miss E had been in relationship since January 2016 following his release from prison. We understand they both knew one another in 2012 when they were both living in accommodation provided by Taunton Association for the Homeless, albeit different properties. Miss E has two children, however both of these reside with grandparents and the latest position is that Miss E has had infrequent contact with her children for some time. There had been a number of third party reports to the police between January 2016 and April 2017, all from Miss E's address, some categorised as domestic abuse related and others anti social behaviour. None of the reported incidents involved children present at her address. Miss E was also known to the Somerset Drug and Alcohol Service, however in August 2015 she had successfully completed a suspended sentence order whilst being managed by the Bristol,

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Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company for a drug related offence.

- 3.4 As a result of Mr D's drug use he was also known to the police, his GP, and local hospital trust because of his poor health. Mr D did not disclose to any agencies that he was being abused by his girlfriend Miss E, however there was one occasion in January 2017 where Mr D reported he had been assaulted by Miss E. Domestic incidents were identified by agencies, however not all possible action was taken.
- 3.5 Incident summary:
- 3.5.1 In April 2017, a third party reported to the police that they could hear violence and banging coming from Miss E's flat, the caller also added that they could hear the female being violent and shouting. Police attended the address and it was reported by Mr D to the officer that they had been arguing about Mr D's drug use. He advised that he had tried to leave however Miss E didn't want him to. No physical violence was reported by neither Mr D or Miss E. Mr D was advised by the officers to leave the address for a 'cooling off' period.
- 3.5.2 The day after the above incident in April 2017, Mr D's body was found hanging from a tree. The police were called and shortly after their attendance Miss E and her friend appeared. Miss E advised officers that Mr D had used a recipe of drugs that day including heroin and 'base' and that they had had an argument the previous day but after a walk around the block he usually returns but hadn't on this occasion.
- 3.5.3 It was concluded by the Coroner that Mr D's death was caused by 'deliberately suspending himself by the neck whilst under the influence of heroin, his intentions at the time were not clearly established'.
- 3.5.4 The police continue to investigate whether any other persons were present prior to and during his death.
- 3.6 The key purpose of this review is to enable lessons to be learned from Mr D's 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, and most importantly, what needs to change in order to reduce the risk of such a tragedy happening in the future.
- 3.7 The Review considers all contacts/involvement agencies had with Mr D and Miss E during the period January 2012-April 2017, as well as any events, prior to 2012, which are relevant to mental health, violence and abuse.
- 3.8 The DHR Panel consists of senior managers, from both the statutory and voluntary sector, listed in section 2 of this report. All of the agencies who have been part of the Review have assisted in the identification of lessons and committed to implementing action plans to address the lessons.

3.10 The agencies participating in this Domestic Homicide Review are:

- Somerset County Council
- Somerset Partnership NHS Foundation Trust
- Somerset Clinical Commissioning Group
- Avon and Somerset Constabulary
- Knightstone Housing now known as Liverty (SIDAS- Somerset Integrated Domestic Abuse Service)
- Turning Point (SDAS- Somerset Drug and Alcohol Service)
- Community Rehabilitation Company
- Taunton and Somerset NHS Foundation Trust
- Taunton Association for the Homeless.

3.11 As per the Home Office guidance a letter together with the Leaflet on 'Domestic Homicide Reviews' was sent to Mr D's family and Miss E asking both whether they wished to engage in this review. Unfortunately, neither replied to this invitation and therefore this review has been solely based on the records held by agencies as opposed to opinions and intelligence from family members and friends.

3.12 Sanctuary Housing Group were also invited to be part of this Review and provided some initial information at the beginning of the process. This was because the property in which Miss E lived was owned and managed by Sanctuary Housing. However, they did not fully engage with this review and therefore there is no learning to be shared for this agency.

4. Parallel Reviews

4.1 There were and are no other statutory parallel reviews ongoing.

4.2 There was a Coroner's Inquest for Mr D. Conclusion recorded above in paragraph 3.5.3

5. Timescales

5.1 On 3rd May 2017 Safer Somerset Partnership received a Domestic Homicide Review referral relating to Mr D from Avon and Somerset Constabulary. Following an initial exercise of information sharing with a range of agencies a decision was made by the Chair of the Safer Somerset Partnership to not undertake a review. Safer Somerset Partnership wrote to the Home Office on 20th June 2017 advising them of their decision not to commission a review on the basis that the two main agencies who had had contact with Mr D were already undertaking their own internal reviews of contact and investigation. On 18th August 2017 the Home Office responded to this decision advising that a formal review should be undertaken following the latest guidance published in December 2016 and that a proportionate review should be conducted that dovetails with any other reviews.

- 5.2 The Home Office Multi Agency Statutory Guidance advises that where practically possible the DHR should be completed within 6 months of the decision made to proceed with the Review. In this case, due to the decision making surrounding the circumstances of this case the DHR Chair was not appointed until October 2017. Arrangements were made to convene the first Panel meeting for November 2017 with the expectation of commissioning IMRs (Individual Management Reviews) and completing the review by the end of June 2018.
- 5.3 The third Panel meeting was scheduled for 20th April 2018 to discuss the overview report. The Review was completed on 31st July 2018.

6. Confidentiality

- 6.1 The findings of this Review are restricted to only participating professionals and their line managers, until after the Review has been approved by the Home Office Quality Assurance Panel.
- 6.2 As recommended within the 'Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' to protect the identity of the deceased, and her family, the following pseudonyms have been used throughout this report.
- 6.3 The name Mr D is used for the deceased, who was 36 years at the time of his death and the name Miss E for his most recent partner; both of these names were all agreed by the DHR/DSR Panel. The other pseudonyms used included Mr F, Mr G Miss H and Mr J; these were all neighbours, acquaintances or friends of Mr D or Miss E.
- 6.4 After this Overview Report has been through the Home Office Quality Assurance process, a decision on whether to publish it will be made by the Safer Somerset Partnership. If it is to be published, the Report and appendices will firstly be fully redacted.
- 6.5 A redaction may simply replace a name with a pseudonym, or may be the removal of personal and sensitive details about an individual, i.e. medical information. Redactions will not be used to protect the identities of the agencies participating in the Review.
- 6.7 The sharing of information between agencies in relation to the DHR was all underpinned by a Confidentiality Statement which each individual read and signed at the beginning of the review (Appendix B). An information sharing protocol was and currently is in place which all agencies represented on this panel are signatories to, this agreement is underpinned by the Crime and Disorder Act 1998 which the Safer Somerset Partnership have in place.

7. Dissemination

- 7.1 Each of the Panel members (see list at the beginning of report), the Chair and members of the Safer Somerset Partnership have received copies of the Report.

8. The Terms of Reference

8.1 Commissioner of the Domestic Homicide Review

- 8.1.1 The chair of the Safer Somerset Partnership has commissioned this review, following notification of the death (suicide) of Mr D in the Taunton area of the county. The alleged perpetrator of domestic abuse was his partner Miss E.
- 8.1.2 All other responsibility relating to the review commissioners (Safer Somerset Partnership) namely any changes to these Terms of Reference and the preparation, agreement and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Partnership.
- 8.1.3 The resources required for completing this review will be secured by the chair of the Safer Somerset Partnership.

8.2 Aims of Domestic Homicide Review Process

- 8.2.1 Establish what lessons are to be learned from this domestic abuse related death regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- 8.2.2 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- 8.2.3 To produce a report which:
- summarises concisely the relevant chronology of events including:
 - the actions of all the involved agencies;
 - the observations (and any actions) of relatives, friends and workplace colleagues relevant to the review
 - analyses and comments on the appropriateness of actions taken;
 - makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they've experienced.
- 8.2.4 Apply these lessons to service responses including changes to policies, procedures, and awareness-raising as appropriate.

8.3 Timescale

- 8.3.1 Aim to complete a final overview report by 31st July 2018 (tbc) acknowledging that drafting the report will be dependent, to some extent, on the completion of individual management reviews to the standard and timescale required by the independent chair.

8.4 Scope of the review

- 8.4.1 To review events up to the domestic abuse related death of Mr D in April 2017, unless it becomes apparent to the independent chair that the timescale in relation to some aspect of the review should be extended.
- 8.4.2 Events should be reviewed by all agencies for a minimum of 5 years (i.e. April 2012) preceding the domestic abuse related death. N.B where an agency holds a significant amount of detail not deemed relevant for the review to seek confirmation from the Chair for inclusion or not.
- 8.4.3 To seek to fully involve the family, friends, and wider community within the review process. The Home Office (*letter dated 18.8.17*) specifically ask that these are involved, as the quality and accuracy of the review is likely to be enhanced and may reveal important information or disclosures which may not have been shared with any agencies.
- 8.4.4 Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.
- 8.4.5 Consider how (and if knowledge of) the risk factors surrounding domestic abuse are fully understood by professionals, and the local community – including family and friends, and how to maximise opportunities to intervene and signpost to support.
- 8.4.6 Explore whether “situational couple abuse” was a factor in this case, and if so determine whether agencies recognized and responded to this dynamic.
- 8.4.7 Determine if there were any barriers Mr D faced in both reporting domestic abuse and accessing services. This should also be explored against the Equality Act 2010’s protected characteristics. The Home Office (*letter dated 18.8.17*) stated that “The DHR should consider the dynamics of the relationship and also explore whether there were any barriers to reporting the abuse or accessing services”.
- 8.4.8 To involve the Somerset Drug and Alcohol Service “Mortality and Morbidity” review learning as far as is practical, to ensure minimal duplication for the 2 reviews. The Home Office (*letter dated 18.8.17*) concluded that this death meets the criteria for a DHR and a proportionate review should be conducted that dovetails with the other reviews.
- 8.4.9 Review relevant research and previous domestic homicide reviews (including those in Somerset) to help ensure that the Review and Overview Report is able to maximise opportunities for learning to help avoid similar homicides occurring in future.

of transfers from one specialist domestic abuse service to another. To include specific consideration of when those agencies are not within the same commissioning authority area.

9. Schedule of the Domestic Homicide Review Panel Meetings

- First Panel Meeting- November 2017
- Second Panel Meeting- January 2018
- Third Panel Meeting- April 2018

10. Methodology

10.1 This Report has been compiled using information and facts from the following:

- IMR presentations from the following agencies;
 - Avon and Somerset Constabulary
 - BGSW Community Rehabilitation Company
 - Somerset Clinical Commissioning Group
 - Somerset Drug and Alcohol Service
 - Taunton and Somerset NHS Foundation Trust
 - Somerset Partnership NHS Foundation Trust
 - Taunton Association for the Homeless
- A chronology of events leading to the suicide of Mr D, coordinated and produced by Safer Somerset Partnership
- Discussions during the Review Panel Meetings;
- Consultations with Safe Lives, a national agency leading on the development of MARACs and Sanctuary Housing, a housing association/provider where Miss E resides.

11. Contributors to the Review

11.1 Whilst there is a statutory duty that bodies including, the police, local authority, probation and health authorities must participate in a DHR; in this case nine agencies have voluntarily contributed to the review (listed in para 3.10) from the Safer Somerset Partnership.

11.2 Family members and Miss E did not respond to the invitation made by the Independent Chair to contribute to this review as previously advised in para. 3.11.

12. The Facts

12.1 Mr D was a bisexual gentleman who had had relationships with both men and women and was 36 years of age at the time of his death. It is unclear when he first started

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using drugs however his GP records indicate that he was misusing alcohol and cannabis in the early 2000s. He was a long-term opiate user and started to use heroin in 2004.

- 12.2 Since 2006 he had undertaken various detox programmes both in the community and whilst serving criminal convictions in prison (2009-2010) however following these interventions he would always relapse. He had never been able to stabilise on a script long enough to engage in any psychosocial treatment, this was particularly the case more recently between January 2016-April 2017 with the Somerset Drug and Alcohol Service.
- 12.3 Mr D was also known to Taunton and Somerset NHS Foundation Trust (the local acute hospital Trust) because of injuries incurred as a result of assaults, continuous drug use and road traffic incidents whilst he was riding his bike.
- 12.4 As a result of his drug and alcohol misuse, there is evidence that he was involved in excess of 100 police contacts. These contacts with the police included drug related stop and searches, reports/intelligence related to theft, possessions and supply of drugs, anti social behaviour, public disorder and begging.
- 12.5 A number of these police incidents transpired into criminal convictions and sentences where Mr D was supervised by Probation. In 2012, Mr D's existing Community Order was revoked and replaced with a revised Community Order and a Drug rehabilitation requirement. Mr D was warned by the Judge that should he breach he would be sent to prison for 3 years.
- 12.6 Mr D did not have a stable residency in Taunton for many years. He moved in and out of one of the Houses provided by Taunton Association for the Homeless (TAH) on numerous occasions. It is unclear what his relationship was like with his family. However, in 2012 whilst under the revised Community Order he moved in with his ex-partner Mr F (pseudonym). This is where we learn that he had same sex relationships in the past.
- 12.7 There are a small number of references by his GP and Probation prior to 2013 where Mr D experienced low mood and suicidal ideation, however he was not referred to secondary mental health services at this time.
- 12.8 In October 2013 Mr D attended Court for shoplifting and was sentenced to a suspended sentence order of 10 weeks' imprisonment suspended for 12 months.
- 12.9 In December 2013 Mr D attended Court again for shoplifting where his suspended sentence was activated, and he was also formally charged with possession and supply of Class A drugs.
- 12.10 In February 2014 Mr D attended Court and was sentenced to 48 months' imprisonment for possession and supply of class A drugs.

12.11 During his time in Her Majesty's Prison Mr D undertook a number of drug rehabilitation programmes and education programmes. His parents had attended at least one of the meetings at the prison to offer support and praise to Mr D in commending the progress he had made. It is also understood that whilst Mr D was in prison he spent a period of time in segregation owing to being bullied by other inmates due to a tobacco debt he incurred. When agencies were planning with Mr D his release it was made clear the importance of a fixed address. His parents articulated that moving back to Taunton amongst his peers was not a good idea. Mr D advised that he intended to stay with his parents temporarily until an opportunity came up at the Abstinence based housing placement provided by Somerset Drug and Alcohol Service to continue treatment for his misuse of alcohol. There is no evidence that this action was taken by SDAS, however this was the aspirational position at the time and discussions of this nature had been had with Mr D and his parents.

12.12 On 15th January 2016 Mr D was released from prison with the following standard licence conditions; not to reoffend and to reside where has been agreed and stipulated. Mr D was free from all substances including methadone and whilst meeting with Probation they agreed that peer pressure and alcohol use were the key risks. Mr D's goal was to only drink at the weekend, maximum of three pints and not to drink with negative people.

From 16th January until 19th April 2016, Mr D was seen on a weekly basis by the Community Rehabilitation Company (CRC) the privatised arm of Probation. The conversations were mainly focussed around accommodation and Mr D securing work. All drug tests had been negative each week. However, on 18th April 2016 Mr D tested positive for use of opiates (heroin).

12.13 On 29th April 2016, Mr D attended the Probation office and gave another positive drug test however he advised the Probation officer he had not used drugs. Mr D also articulated how he felt disappointed because he had still not secured a job.

12.14 On 13th May 2016, Mr D attended the CRC office and met with his Probation officer and gave another positive drug test for heroin and cocaine. It is noted that the Probation Officer believed he seemed despondent at not finding work but seemed well in himself.

12.15 On 20th May 2016, Mr D attended once again the CRC office and gave another positive drug test for heroin.

12.16 On 26th May 2016, Mr D attended the Probation office with good news that he had secured work as a kitchen assistant. He also admitted to the Officer that he had relapsed and used heroin but could not explain why.

12.17 A Dry Blood Spot Testing test results were received by SDAS on 27th May 2016 indicating Mr D had shown Hepatitis C antibody positive and was therefore due to attend various hospital appointments for treatment.

- 12.18 The first incident reported to the police regarding Mr D and Miss E was made by a third party (neighbour) called Mr G on 16th June 2016. It was reported by this individual that Mr D and Miss E had been arguing and Miss E was throwing items at Mr D. Police attended and spoke to both parties. Miss E confirmed that only a verbal argument had taken place because she had relapsed and taken amphetamine. Miss E admitted she had been unkind towards Mr D. A DASH (Domestic Abuse, Stalking, Harassment and Honour Based Violence) risk assessment was completed with Miss E, as the victim, which found that Mr D posed a standard risk of harm towards Miss E. A DASH was not completed with Mr D at this time. Miss E advised the officer that she had relapsed one week ago after being clean for two years and suffered from depression. It was noted by the officer that Mr D was an ex-heroin addict and a trainee chef, no further details or risks were assessed. Both parties advised that they were no longer using drugs.
- 12.19 On 23rd June 2016, Mr D attended the Probation Office. He advised he had used drugs but was now back on track.
- 12.20 On 25th June 2016, Mr D attended the Emergency Department at Taunton and Somerset NHS Foundation Trust following a road traffic accident where he had taken heroin and then been knocked off his bike. He had ruptured his spleen and needed an operation. Whilst admitted he advised staff that he lived with his parents, was a trainee chef and stated that he was not addicted to substances. However, a referral was sent to Somerset Drug and Alcohol Services (SDAS) and whilst in hospital he advised that he would arrange to begin treatment with SDAS the day after discharge. The hospital recorded that a girlfriend visited him whilst he was in hospital.
- 12.21 On 30th June 2016 there was liaison between SDAS and the hospital regarding his treatment for substance misuse.
- 12.22 Mr D was discharged from hospital on 4th July 2016.
- 12.23 An initial assessment was arranged on 4th July 2016 with Mr D by SDAS. This assessment was completed on 5th July 2016. Mr D presented for his assessment as eager to engage following the bike accident last month. A discussion was had about how he managed his hepatitis C and his current drug treatment plan as discussed with medical practitioners whilst in hospital. Mr D stated as part of this assessment that he has suffered from depression in the past but did not have any suicidal thoughts, ideation or self harm. Mr D told the SDAS worker that he lives with his parents but sometimes stays with his girlfriend. Risks of substance misuse, relapse, and his physical health were all identified, and a referral was made to the recovery team within the same organisation for stabilisation and detox/relapse prevention.
- 12.24 Four days later on 8th July 2016 Mr D met with the clinical lead from the SDAS recovery team. Mr D reported that since relapsing after his release from prison he was injecting £10 worth of heroin and £10 worth of crack cocaine into his groin. It is reported by the clinician that he appeared calm, relaxed and generally stable in his mental health. He also advised at this consultation that he was in a 4-month old

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relationship however resides with his parents. At the end of this consultation a plan was agreed between Mr D and the clinician to begin a prescribed script of methadone and support to address his use of illicit substances.

12.25 On 12th July 2016 Mr D attended the Probation office as scheduled. It was reported to be a short meeting and the officer noted Mr D's spirits were high. Mr D reported that he has not used drugs since the accident. Later that day Mr D was due to attend the hospital for a herpetology appointment which he did not attend.

12.26 On 21st July 2016, the police were called to attend the second incident involving Mr D and Miss E at Miss E's address. This was reported by a third party, a neighbour stating that the couple were shouting at each other. It was believed by the neighbour that they could hear Miss E crying and Mr D shouting 'ow' suggesting that he was the victim. Officers attended the address, Miss E advised she felt low as she had relapsed 4 days ago and failed to collect her anti-depressants. It was reported that Mr D had been out longer than expected and when he returned she smashed a glass and threatened to cut her arm. Mr D had grabbed the glass from her and cut his finger. Both parties were spoken to. No other advice was given.

12.27 The following day, the police attended again following another complaint by a neighbour after hearing an argument between the couple. Officers asked both parties what had happened, and both denied that there had been any argument. Miss E seemed unwilling to engage however advised that they had had an argument yesterday.

12.28 A number of days later a police contact was made as a result of an alleged incident reported by a neighbour. Officers attended the address where both Mr D and Miss E denied that any argument had taken place.

12.29 On 28th July Mr D attended the Probation Office for a planned visit. He advised his probation officer that he had not used any illicit drugs but occasionally would drink. He spoke well of his relationship with Miss E.

12.30 Another police incident was reported on 30th July 2016 by a neighbour stating they could hear an argument between Miss E and Mr D involving lots of shouting and things being smashed around. It was added that Miss E was crying quite frantically. Officers attended and reported that they could see the couple arguing through the window on attendance. Once spoken to Miss E denied any argument had taken place. There was no sign of any objects having been thrown and a DASH was refused by Miss E. It is unclear whether a referral to victim of crime services was made for Miss E however it was noted by officers that she was not willing to engage.

12.31 On 11th August 2016, neighbours reported another domestic incident stating that Mr D and Miss E were fighting, and Miss E was being hit and having her hair pulled. Officers attended to find Mr D, Miss E and another female called Miss H present. All three denied any argument had taken place although Mr D advised that he did not

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want Miss H to be in the property. Miss H left and details from Miss E and Mr D were refused therefore a DASH was not completed.

- 12.32 On 19th August 2016 Police attend Miss E's address again as a result of a third-party neighbour complaint. Neighbour reported that there was a lot of disturbance coming from Miss E's flat and that she had heard a female crying and earlier than that some banging. Upon attendance at the property by officers, Miss E and Mr D denied any argument had taken place and stated that their neighbours are trying to get them kicked out. There were no signs of disturbance or injuries. A DASH was refused by Miss E, however based on observations a DASH was completed on return to the station by the attending officers which suggested the risk was standard.
- 12.33 Two days later the police were called again by neighbours reporting that Mr D and Miss E were arguing, and Miss E was screaming and crying. Officers noted that shouting could be heard upon attendance at the property. Officers separated both parties. Miss E was shouting at Mr D asking him not to leave and Mr D was also saying that he just wanted to leave to go home. There were signs of things being thrown with food and dinner plates smashed in the property. Miss E advised she had relapsed into drug use and not taken her anti-depressants for a number of days. An ambulance was called to check on Miss E's welfare. Miss E returned to a normal state and a DASH was completed with Miss E which was deemed to be standard risk. Mr D left the property.
- 12.34 In the early hours of the following morning, police were called by a neighbour again reporting violent rowing between the couple. Police attended and struggled to gain access to the property or contact from Miss D's mobile as there was no answer. It is noted in police records that there was no domestic incident, an argument had happened earlier (previous day) and when police attended on this occasion both Mr D and Miss E were sleeping.
- 12.35 On 25th August 2016 Mr D attended the Probation Office, it was noted that he had a swollen hand however it is unclear whether the officer had asked him how this had happened. He said that he had relapsed once since the last appointment but work was going well.
- 12.36 Police attended Miss E's address on 29th August 2016, this was the tenth incident in two months. Neighbours reported that they could hear screaming and shouting and that it sounded as though it was becoming more violent. The neighbour added that it had been going on for about 45 minutes and that when the police attend it quiets down but starts again as soon as the officers leave. Following attendance by officers Mr D had already left and therefore time was spent with Miss E. Miss E said that there had not been any violence and that it was a verbal altercation only. A DASH was completed at the time which was medium risk, but no referral was made to Somerset Integrated Domestic Abuse Service because Miss E did not consent to this and the incident was a verbal argument only. A search was conducted for Mr D in the local area, but he was not found.

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- 12.37 Another police incident was reported on 30th August 2016 with a complaint by a neighbour that they could hear Mr D and Miss E shouting and throwing things. The neighbour also stated that they could hear the male shouting as if he was in pain. Officers attended the address and Mr D and Miss E said that there was nothing to report and that this was other people calling the police for no reason.
- 12.38 Two days later on 1st September 2016, the police attended Miss E's address again, the neighbour reported that Miss E and Mr D were arguing and that this can turn violent. It was also added that Miss E does self harm and that they can hear things being thrown around. Officers attended the address and spoke to both parties. It was reported by the officer that this was a verbal argument and that a DASH was attempted with Miss E by the officer, but this was refused therefore an officer concluded that the incident represented that of a standard risk posed by Mr D on Miss E. Later the same day another report was made by neighbours advising that they could hear Mr D and Miss E fighting, objects being thrown, and screaming. The neighbour also added that Miss E had told them that she had hit Mr D in the past. Officers attended following this report and spoke to Mr D and Miss E separately. Mr D said Miss E was agitated by returning to using drugs and Miss E said Mr D had said some horrible things which had caused her to cut her arm. Officers noted injuries on her arm and recorded that they appeared to be caused by needles. Both Mr D and Miss E admitted to using drugs and Mr D was asked to leave the property for a period of time. A DASH was completed with Miss E stating that the risk was standard with the overwhelming issue being drug use causing a strain on their relationship.
- 12.39 On 9th September 2016, neighbours report a further incident to the police because they could see into Miss E's address that she was throwing things around. Officers attended and found Miss E in bed crying, both state that they have had a verbal argument only. Miss E said she had called the ambulance earlier in the evening because Mr D was having an asthma attack and he had called her an offensive name. She admitted that she had smashed a glass belonging to her and both had used drugs together. Mr D left the address to stay with his parents. Miss E mentioned that she does have two children who live with her grandmother. A DASH was completed with Miss E which determined Miss E to be at high risk of harm from Mr D, these details were not referred onto support services. The rationale being that there had been a number of incidents reported, both parties were seen to be unstable using drugs and there was a concern for her mental health. The officer believed that they both had capacity to harm themselves and one another. A referral was made to Children's Social Care.
- 12.40 Later the same day another incident was reported to the police by a neighbour who believed they were arguing about money. Officers attended and were advised by both parties that they had argued about taking drugs. Miss E said it was because Mr D wanted to take more drugs and Mr D said it was vice versa. Mr D left the property to go to his parents. A DASH was not completed because the officer stated it was only a verbal argument. The Police attended for a third time that day as a result of another neighbour complaint reporting hearing screaming and shouting from Miss E's property. When police attended there was no sign of any verbal argument and they

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found Mr D and Miss E in bed. Officers were satisfied that there was no domestic incident in progress.

- 12.41 Mr D attended SDAS and advised that he had not collected his script. He was therefore told by the service that he had broken the 3-day rule which meant that his prescribed medication had not been collected for 3 days and therefore it was not safe to prescribe, and he needed to be to have a medical review to assess his current substance use.
- 12.42 On 14th September 2016 police were advised of another domestic incident between Mr D and Miss E by neighbours. The report mirrored previous reports of shouting, screaming, things being thrown around etc. It was added by the caller that they are both as bad as each other but 'the female is worst as she has the biggest mouth'. Police attended and noted that Mr D and Miss E had been arguing all day however were calm upon arrival of officers. No further action was taken.
- 12.43 The following day, police attended Miss E's property twice for two separate incidents reported by neighbours. The first of the two was because banging and swearing could be heard from the flat, and also it was reported that Mr D may have stolen a parcel from the neighbour. Upon attendance by police officers both parties were upset, and Mr D explained that he had just confessed to Miss E that he had cheated on her. Mr D left the property and Miss E completed a DASH with officers which highlighted that Miss E was at medium risk of harm from Mr D. The Officer made a number of observations within the DASH in relation to the frequency of incidents, Miss E relapsed and now using drugs and blames Mr D. Miss E advised that Mr D has never been physically violent but calls her names like 'slut'. The second incident was reported by neighbours who could hear Miss E screaming and shouting at Mr D and the caller thought he could hear Mr D yelling possibly following an assault upon him. When officers attended Mr D was not present and Miss E advised that they had had an argument earlier in the day but that she had been having problems with neighbours.
- 12.44 A referral by the police was made to the Somerset Integrated Domestic Abuse Service on 19th September 2016 with Miss E identified as the victim. However, information was not shared to identify the perpetrator and unfortunately despite numerous attempts successful contact was not made with Miss E.
- 12.45 The next police incident was made on 24th September 2016 by a neighbour who reported that there were concerns that Miss E was drug dealing from her flat. Officers attended but there was no answer or information to corroborate this. No further action was taken.
- 12.46 On 26th September 2016, Mr D attended the emergency department at the acute hospital because of an injury with his hand which he had got from punching a wall. He was treated for cellulitis.

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- 12.47 Mr D met with SDAS on 29th September 2016 to review his treatment plan following the 3 consecutive days of not collecting his prescribed medication. He stated that he struggled to get his script because of working split shifts at the hotel. A urine sample confirmed positive use of opiates, amphetamines, benzodiazepines and crack cocaine. After a discussion, it was agreed he would commence a new treatment script the following day.
- 12.48 On 5th October 2016 he failed to attend an orthopaedic appointment at the hospital.
- 12.49 On 6th October 2016 Mr D attended the Probation Office, he said he had used heroin 6 days ago but generally he had avoided it. He also disclosed that he had split from Miss E but felt this was for the best. He added that there had been some disruption where he works and that it was no longer a good place for him to work.
- 12.50 On 9th October 2016 Mr D was taken to the emergency department at the acute hospital by ambulance with abdominal pain. There were no signs of an acute abdomen ailment and therefore he was discharged. Mr D then attended the hospital the next day, 10th October, and the 11th October with the same symptoms. He left the hospital on 11th October 2016 against medical advice.
- 12.51 Mr D failed to attend his second orthopaedic appointment on 14th October 2016.
- 12.52 In November 2016 Mr D attended the GP when he reported worsening mood in recent months related to his social circumstances of having no fixed abode as well as further arrests. He stated that he was living with his parents at that time with poor sleep and low mood. He reported fleeting thoughts of self-harm but no intent and stated to the GP at that time 'he would not do anything'. He wished to improve his situation and agreed to restart the antidepressant mirtazapine (which had been used in 2013 for 4-5 months for depression). He continued ordering this medication until his death.
- 12.53 His next appointment to see his probation officer was on 17th November where he advised that he was still no longer with Miss E, that he occasionally was using heroin and had limited work post a hand injury.
- 12.54 Mr D attended the emergency department on 22nd November 2016 due to a shortness of breath related to recreational drug use.
- 12.55 On 1st December 2016, Mr D attended the Probation Office for a planned visit. He advised he was still looking for work and was engaging well with SDAS. It is unclear whether a drug test was done at this time.
- 12.56 On 12th December 2016, Mr D attended SDAS for an appointment where he reported he was still using heroin sporadically by injecting into his groin. His treatment plan was re-assessed, and Mr D advised the worker of a bite mark he had on his arm which he said was sustained from another drug user who Mr D stated has hepatitis C, their name was not disclosed. SDAS worker advised it looked infected and that he should go

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to A&E to have it looked at. There is no record that Mr D attended the acute hospital at this time to have his bite mark assessed and treated.

- 12.57 On 20th December 2016, Mr D attended the Taunton Association for Homeless (TAH) asking for a room which was successful.
- 12.58 The following day on 21st December 2016 Mr D visited the SDAS service to inform them that he had not collected his script on three consecutive days again. It was noted that he did not look well but he agreed to restart a treatment plan and script. He advised that he had recently been able to move into a room provided by the TAH and that prior to this he had been on the streets after his parents asked him to leave their house.
- 12.59 On 28th December 2016 SDAS were informed by the local pharmacy that Mr D had again failed to collect his prescribed medication for three consecutive days.
- 12.60 On 29th December 2016, Mr D attended the SDAS office asking to be restarted on a treatment plan. SDAS informed Mr D that he could have restarted the previous day but that there weren't any free appointments until 3rd January 2017. Mr D was not happy with this and asked what he was supposed to do until then, at this point SDAS gave Mr D harm reduction advice.
- 12.61 On 5th January 2017 Mr D attended the emergency department at the acute hospital following being picked up by police under the section 136 Mental Health Act because Mr D was complaining of feeling suicidal. This is the point where Somerset Partnership NHS Foundation Trust had some involvement with Mr D by undertaking an assessment. The assessment revealed that Mr D had taken a 'cocktail' of drugs to include speed, heroin and cocaine. He also reported to have fallen out with his girlfriend and was currently homeless. He also advised the assessor that he was now in a heterosexual relationship having had homosexual relationships in the past. The outcome of the assessment found that he did not have a mental health disorder and had sufficient mental capacity to make decisions about his health and welfare. He was therefore assessed as not requiring any future support or service from Somerset Partnership NHS Foundation Trust. It is also noted that the assessor advised Mr D to engage with SDAS however this was not followed up with any proactive information sharing or referral.
- 12.62 Five days later Mr D met with SDAS to discuss consideration of restarting treatment. His current medication was reviewed, a urine test confirmed positives for opiates and cocaine. He advised he was living in a house provided by TAH and was looking for work. Agreement was reached between the medical practitioner and Mr D that he would begin a treatment of buprenorphine which partially blocks the effects of opiates and that this would commence the following day.
- 12.63 On 12th January 2017, Mr D appeared at Taunton Magistrates Court which was attended by Probation. He had been arrested and charged with theft from his mother of a BOSE CD player the previous day and appeared from overnight custody. Mr D

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pleaded not guilty and this was adjourned until 3rd February 2017 for a case management hearing. The same day Mr D attended the Probation office. He said that he and his father had jointly bought the stereo for his mother and that he had taken it to 'cash converters' due to benefit problems. Mr D also reported that he was still looking for work and on a drug treatment plan with SDAS.

12.64 On 15th January 2017, Mr D reported to the police that he had been beaten around the head with Miss E's fists and a glass candle holder. He also said that he had been hit by Miss E in the past but has never reported these incidents. It was noted by the call handler that Mr D sounded very upset on the phone. Officers attended Miss E's address and noted that there was no noticeable damage, however only Miss E was present who said that Mr D had just left after an argument. Police looked in the surrounding area for Mr D who was then located sat in the emergency department at the acute hospital. Mr D said he had been bitten on his chest, kicked and punched in the testicles and hit over the head with a candle holder. Mr D did have bite marks on his chest and back; this was recorded by the acute hospital. Mr D was asked to attend the station the following day to make a statement and complete a DASH risk assessment. Later the same day Miss E was arrested.

12.65 When Mr D attended the station to provide a statement he stated that he had borrowed money off Miss E and used it to get drugs instead of pain killers for her which caused an argument that led to a physical assault. Mr D said he was willing to prosecute however refused to complete a DASH. Nevertheless, a DASH was completed by officers who graded this as a medium because of physical injuries and evidence of being in a volatile relationship. A referral was made to children social care due to concerns for Miss E's children and whether they were having contact with their mother whilst she was misusing substances. A referral to the Somerset Integrated Domestic Abuse Service was not made at this time for Mr D.

12.66 On 19th January 2017 Mr D abandoned his room at TAH.

12.67 On 27th January 2017 Mr D attended the emergency department at the acute hospital by ambulance owing to feeling unwell and severe right hand and left leg cellulitis. He was admitted for clinical care and admitted that he uses heroin, speed and cocaine on a regular basis. He had a human bite mark and advised that he lives with his partner, despite this disclosure there is no evidence that further questions were asked by staff about the bite mark which may have highlighted safeguarding issues. On two occasions he left the ward to go for a walk without making the nurses aware and then was discharged the following day.

12.68 Two days following discharge Mr D attended the emergency department again by ambulance feeling unwell. He presented as unwell and was treated whilst investigations were carried out. On the same day, SDAS were made aware by the pharmacy that Mr D had not collected his prescription from the pharmacy since 23rd December 2016.

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- 12.69 On 1st February 2017 Mr D was seen by SDAS following discharge from hospital regarding his drug treatment plan and prescription. A discussion was had about his medication and dosage and a further appointment was required at a later date to have a full clinical review. It was noted by the SDAS worker that Mr D did not look well.
- 12.70 On 3rd February 2017, Probation have noted that Mr D failed to attend court regarding the case management hearing of the theft of his mother's stereo. Later that day it was reported to the police that a friend of Mr D named Mr J stating that Mr D had just left his property saying he wanted to kill himself and he took tablets in front of Mr J, he had said he had used a bag of heroin and left with a bag of tablets. Police spoke with Mr D who said he hadn't taken an overdose and was just going to see a friend, it was reported that Mr D seemed happy and there were no concerns for his welfare.
- 12.71 The following day a room was offered by TAH to Mr D, however he refused to stay. The same day he attended the emergency department at the local hospital complaining of feeling unwell with cellulitis again. SDAS was contacted to confirm methadone dose. Mr D complained to the medical practitioners within the department that he did not have anywhere to live, he was advised to go to housing about accommodation. He was discharged from hospital two days later.
- 12.72 An internal review of Mr D's case was undertaken by Probation.
- 12.73 On 11th February 2017 Mr D appeared at Court following his arrest under warrant the previous day. Probation were at court to take a record of this moment. He advised he had failed to attend on 3rd February due to being in hospital with cellulitis. His case was adjourned until 17th February and was ordered to abide to bail conditions; to report to the local police station between 12-6 on a daily basis. Mr D told the court he was staying at the house provided by TAH when this was available.
- 12.74 A number of days later he appeared at Court again where the trial date was set for 14th March 2017 regarding the theft of the stereo from his mother.
- 12.75 Three days later on 20th February 2017, Mr D attended the SDAS office to see the clinical lead. Mr D expressed at this visit that he wished to be on a stable prescription rather than a script and wanted to turn his life around in order that he could find stable accommodation.
- 12.76 On 23rd February 2017, police were called by one of Miss E's neighbours regarding screaming, banging and shouting coming from Miss E's flat and a male becoming very angry. Police attended and were informed by Mr D and Miss E's friends that the couple had had a verbal argument and that they had left the flat to cool off. Officers located Miss E who informed them that Mr D was not at the flat but that her friends had started an argument and she had left to get away from them. The same day Mr D attended the Probation office, he said he was staying at Miss E's address at the moment as was currently of no fixed abode. He expressed that he was still looking

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for work and wanted to change his life around and that he had an appointment with SDAS the following day to discuss detox programmes because he hadn't used heroin in 4 days.

- 12.77 On 8th March 2017, Mr D's case was reviewed by the senior clinician and the complex case management team within the SDAS service. This was due to the repeated failure to maintain engagement in treatment and achieve stability on a script. It was suggested that a full medical was needed and this was actioned.
- 12.78 The following week on 14th March 2017 Mr D attended Court where he was tried for the theft of his mother's stereo. He was found guilty and was given a financial penalty. After this, Mr D attended the Probation office where he advised that he had been begging for money to pay off debt and that he was looking for accommodation through a local initiative 'Open Door'. He also added that he had had pneumonia in the autumn 2015 and that this had affected him physically.
- 12.79 On 19th March 2017 Mr D attended the emergency department at the local hospital twice, the first he attended with abdominal pain but declined to be assessed as he felt he had waited too long. Later that day he attended via ambulance again, this time complaining of a gastrointestinal bleed, he had been found in public toilets vomiting and said that he lived with his girlfriend. He said he had been kicked in a fight the night before, there was no evidence that any professional curiosity was used to better understand the circumstances surrounding Mr D's injuries and ailments. His symptoms were treated, he was prescribed methadone and had an acute kidney injury. He was discharged 3 days later.
- 12.80 On 24th March 2017, SDAS were advised by the local pharmacy that Mr D had presented to collect a script, but the pharmacy was unaware of this because he had been discharged from the hospital and they were unable to confirm if Mr D had received methadone between 20th-24th March.
- 12.81 Four days later Mr D attended the emergency department again by ambulance complaining of abdominal pain. His symptoms were treated, Mr D added to the medical practitioners that he was of no fixed abode because although there was accommodation at the house provided by TAH he did not want to live there because it was full of people on non-psychoactive substances.
- 12.82 In early April 2017 he was seen by the GP and was given a sick note. 5 days later, Mr D failed to attend the follow up appointment with the GP.
- 12.83 The next day (following the non-attendance at the follow GP appointment), Mr D then failed to attend the Re-start appointment with SDAS. This information was shared with the GP and noted by the GP the following day in medical records.
- 12.84 The next day, SDAS colleagues sent emails to one another internally to establish a further action plan to try and engage Mr D in motivation enhancement therapy. On the same day police were called to Miss E's flat following a neighbour who reported

that they could hear banging and violence coming from Miss E's flat and that this had happened earlier that day also. The caller stated that they could hear the female being violent and shouting as well as the doors and units being slammed shut. Police attended the address and spoke to the couple separately. Mr D advised that they had argued because of his drug use and that they had only been back together for two weeks.

Mr D said he had tried to leave that day, but Miss E didn't want him to but that there had not been any violence. Miss E said that her neighbours did not like her associating with drug users and that she was upset with this which led to an argument with Mr D. Officers advised that Mr D should leave the property for a 'cooling off period'. Information was taken at the time of the incident by the attending officers for the completion of a DASH. The DASH was not inputted onto the system until the following day.

- 12.85 Sadly, less than eight hours later Mr D's body was discovered by a member of the public hanging from a tree. Mr D had taken his own life whilst under the influence of heroin, his intentions at the time were not clearly established.

13. Overview

- 13.1 The Panel have been committed to the Review, within the spirit of the Equalities Act 2010, and have demonstrated an ethos of fairness, equality, openness and transparency. The Panel have worked as a partnership in ensuring that the Review has been conducted in line with the Terms of Reference. The Review has been cognisant of the Mr D's family and their privacy. Mr D's parents and Miss E were both contacted as part of this Review to ascertain their views about Mr D's lifestyle, interaction with agencies and his relationship. Unfortunately, there was not a response to this invitation and therefore the Review is written in the context of information held by agencies only.
- 13.2 The practices of agencies were carefully considered to ascertain if they were sensitive to the nine protected characteristics of the Equality Act 2010 i.e. Age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race and religion and belief, sex or sexual orientation. In line with the Terms of Reference, the Panel considered these protected characteristics and concluded that although Mr D was a bisexual individual; it was believed by the Panel that his sexual orientation has been acknowledged as part of the review and this was added to the complexity of how to engage and how to access services throughout the review process.
- 13.3 Independent Management Reviews (IMRs) were commissioned by the Independent Chair in November 2017. Seven agencies undertook an IMR and presented this back to the Panel in January 2018. The purpose of an IMR is for the individual organisation to scrutinise their involvement in the case and establish whether policies and practices were adhered to or not. Following this review, the organisation may make recommendations to improve their response to domestic abuse as a result of this case.

13.4 Twenty-two agencies/multi-agency partnerships/departments were contacted about this review initially in the Somerset area and these are listed in Appendix E.

13.5 Eight agencies/partnerships from across Somerset confirmed that they had not had any relevant contact with either Mr D or Miss E. They were:

- A&S MAPPA
- Somerset County Council Adult Social Care
- Somerset Integrated Domestic Abuse Service
- Somerset Safeguarding Adult Board
- South Somerset District Council
- Victim Support
- Yeovil District Hospital
- Somerset and Avon Rape and Sexual Abuse Support (SARSAS)

There were a number of agencies who had had some contact with Mr D or Miss E, but it was not deemed necessary to involve them in the review due to relevancy, detail and frequency of contact.

13.6 The following seven agencies advised that they had had some contact with Mr D of varied frequencies and detail and were invited to attend the Panel meeting to discuss their involvement:

13.6.1 Somerset Drug and Alcohol Service is the dedicated support and treatment service for adults with drug and alcohol misuse issues. Mr D had been known to the agency for many many years and had been supported to undergo numerous treatment programmes, however he could never sustain a script for a long enough period to be put forward for a full recovery programme.

13.6.3 Somerset Partnership NHS Foundation Trust is the main provider of mental health services in Somerset. Mr D had only ever encountered this agency once following the Section 136 Mental Health Assessment in 2017. Suicidal ideation was not deemed to be a risk factor by this agency following their limited involvement with Mr D.

13.6.4 Somerset Clinical Commissioning Group is the main commissioner of health services within the Somerset area including Primary Care services; GP. It was known to Mr D's GP surgery that he was a regular opiate user. Mr D frequently found himself in the emergency department at the local hospital and this information was routinely shared with the GP surgery. His GP surgery were not aware of the incidents reported to the police by neighbours of domestic disputes with Miss E.

13.6.5 Taunton and Somerset NHS Foundation Trust is one of two acute health providers in the county and the one frequented by Mr D often. As above, Mr D was known to this agency following frequent attendances for continued drug use, road traffic accidents when he was knocked off his bike and general health and wellbeing issues. Their focus was on Mr D's clinical care. Interestingly Mr D would advise what his relationship status was to this service on a number of occasions.

- 13.6.6 Avon and Somerset Constabulary provide the police service to the county of Somerset. Mr D was known to this agency for many years for a range of reasons; intelligence and reports relating to his continued drug use and related criminal activity, anti-social behaviour, public disorder and begging. A number of different officers dealt with Mr D and Miss E on a regular basis. Attempts were made to engage Miss E with support services however this will be considered in more detail in the next section of this report.
- 13.6.7 Taunton Association for the Homeless is a voluntary organisation providing supported housing for individuals in Taunton. Both Mr D and Miss E have previously been known to this service albeit at different times. Mr D did stay in one of the rooms offered by this organisation following his release from HMP in January 2016. Mr D did not engage on a very detailed level with the organisation during this time however the agency has found it useful to be part of this review.
- 13.6.8 BGSW Community Rehabilitation Company (Probation) provides rehabilitation and offender management services to help reduce reoffending and protect the public. They work with low and medium-risk offenders, managing their community sentences and providing them with knowledge, skills and support to enable them to stop offending. They also manage and support low and medium-risk offenders who are released from prison on licence, as well as offenders who are sentenced to less than 12 months in custody. Both Mr D and Miss E were known to this service for different periods but during the time of this review.
- 13.9 A chronology was compiled as part of this review given the number of contacts Mr D and Miss E had had with these agencies. A brief summary of this is captured in 'The facts' section of this report.

14. Analysis

- 14.1 The Panel has considered the individual management reviews (IMRs), through the viewpoints of both Mr D and Miss E, to ascertain if the agencies' contacts were appropriate
and
whether they acted in accordance with their set procedures and guidelines. Where they have not done so, the panel has discussed whether the lessons have been identified and appropriately actioned.
- 14.2 The authors of the IMRs have followed the Review's Terms of Reference and addressed the points within it. The agencies undertook the IMRs in an honest, thorough and transparent fashion, ascertaining information from a number of sources. The following is the Review Panel's view on the appropriateness of the intervention undertaken by each agency.

Somerset Drug and Alcohol Service

- 14.3 In the opinion of the IMR author, it is recognised that this agency had a considerable amount of contact with both parties, however particularly Mr D following his release from prison in January 2016. The challenges faced by this organisation with Mr D's chaotic drug use and lack of stability to remain on a script resulted in his treatment being escalated to an internal Complex case review, and this happened on more than one occasion. Despite best efforts actioned following these reviews Mr D still did not engage with the service for a long enough period to begin any psychosocial treatment.

With reference to the points raised above, the IMR also considered what else could be developed when the service is finding some individuals difficult to engage with who meet the threshold for a complex case review. It was found that consideration should be given to what emergency contacts and useful advice is available for these service users in the event of serious distress.

- 14.4 It is noted in the IMR that Mr D did disclose that he had been subjected to violence and had a bite mark. SDAS appreciate that this disclosure was not explored thoroughly enough at the time to establish whether it was domestic abuse and that this was potentially a missed opportunity to learn more about how he was feeling and his situation.
- 14.5 The Panel were advised as part of the IMR presentation and discussion that both Mr D and Miss E were known to the service at the same time and that their relationship was known. The Panel sought assurance from this organisation on what would have happened should any disclosures from either party had been made. In addition, it was discussed whether joint treatment would ever be considered. The outcome was that joint treatment can be considered where both parties request it and all parties agree that this is in the best interest of each individual's treatment. In the case of Miss E and Mr D, this was not requested.

The final point that was raised by this organisation in relation to lessons learnt related to Mr D's risk assessment which was not completed in his absence and was significantly out of date at the time of his death. It was clear from his records held by the service that he had a history of poor mental health and suicidal ideation, intent and attempts. Therefore, it was found as part of this review that 'past' risks identified in the risk assessment were not actively managed.

Somerset Partnership NHS Foundation Trust

- 14.6 As previously articulated in this report, the contact this organisation had with Mr D was limited and related only to an incident in January 2017 where he was detained under the Mental Health Act 1983. It was noted in the IMR that the Policy and Protocol was followed as per standard and an assessment was undertaken which found that Mr D did not need to be admitted to secondary psychiatric care and that it was more critical he engaged with the drug and alcohol service locally.

- 14.7 However, as part of the assessment Mr D disclosed that he often felt suicidal when he had arguments with his girlfriend and that this was the reason for his behaviour on this occasion. Within the IMR and Panel discussion it was highlighted that this could have been an opportunity to explore his situation and feelings further and establish whether he was experiencing domestic abuse from his girlfriend, who we believed to be Miss E although Mr D did not disclose her name to this organisation.
- 14.8 The Panel discussed 'professional curiosity' and how this tends to only feature where the workforce understands in detail the dynamics of abuse and are confident in being able to ask those sensitive questions. This was a shared concern for many of the organisations taking part in this review.
- 14.9 In addition to the above, the IMR author also highlighted another concern where the risk screening and risk information regarding Mr D's disclosure of feeling suicidal was not adequately recorded within his notes.

Somerset Clinical Commissioning Group

- 14.10 It was reported within the IMR and by the author as part of the Panel meeting that Mr D had many contacts with his GP surgery, not always seeing the same GP. Mr D's drug and alcohol use was known by the surgery and how he had a history of experiencing low mood and depression. Suicidal ideation was not disclosed by Mr D to his GP and therefore this was never acknowledged as a risk factor.
- 14.11 The IMR also highlighted that there was often correspondence between secondary care services and the GP practice informing this organisation of the attendances made by Mr D at the local hospital; often accident and emergency for drug related accidents. This is regarded as good practice and enabled health professionals to be kept informed of Mr D's care.
- 14.12 As part of this review, both Miss E and Mr D's contact with agencies was considered, however there was considerable uncertainty and debate as a Panel in relation to whether Miss E's information could be shared. This was of particular relevance to Miss E's health records owing to whether information could be shared without the living person's consent. The Panel concluded that it was essential we seek further guidance from the Home Office about this issue, suggesting that they should discuss this with the Medical Defence Organisations.

Taunton and Somerset NHS Foundation Trust

- 14.13 This IMR was extremely transparent and actions taken at the time with Mr D were critiqued well. Consideration was given to how Mr D was treated by staff clinically as well as a patient and therefore his general wellbeing. In the opinion of the IMR author, more robust questions could have been asked of Mr D when he attended the Emergency department with suspected or actual injuries resulting from assaults, in order to establish whether he was experiencing domestic abuse. Panel members

supported this suggestion and a more detailed discussion was had in relation to what the policy and protocol is in relation to staff within the Trust exploring these questions with patients.

14.14 With particular reference to the policy held by the Trust, it was found that there could be some improvements made to the policy which would aim to strengthen the response medical professionals, working in the Emergency Department, can give to the patients attending. These included clearer advice on when to complete a risk assessment, what questions could be asked when a patient discloses a difficulty in a relationship, and the reminder that victims can be males or females etc.

14.15 It was highlighted by the Panel that where appropriate this organisation did share information with others, for example the Somerset Drug and Alcohol Service and the GP. However, to the contrary it was also found within the IMR that where another agency was involved there was a sense of complacency amongst the staff to deal with the issue because there was an assumption that the other organisation had already undertaken a risk assessment and made any necessary referrals.

14.16 The IMR author also advised in the report that the Trust is currently seeking to employ a Homeless Health Support Worker with local services. This post will aim to support homeless people who attend the Emergency Department. It was discussed and agreed by the Panel that should this post have been in place when Mr D was being seen by this service then additional support may have been available to him which may have also teased out further information about his current situation.

Avon and Somerset Constabulary

14.17 This IMR was also very thorough and each contact with Mr D had been considered in detail. There were in excess of 20 incidents reported to the police regarding Mr D and Miss E and therefore this organisation was critical to understanding what was known about the couple and the status of their relationship.

14.18 Within the IMR, each contact was scrutinised, and the Panel considered each contact. There were a number of contacts which were categorised correctly as a 'domestic incident' however despite neighbours reporting Miss E as the primary aggressor; shouting and reportedly throwing items, Mr D was often seen as the perpetrator and therefore there were missed opportunities to undertake a DASH risk assessment with him as the victim.

14.19 Similarly to the point above, Mr D was not referred to the local specialist support service for domestic abuse or victim support team because he was not recognised as the victim. Mr D had a nickname on police systems of 'Gay [redacted]' yet was not recognised as being bisexual. In addition, what interestingly transpired from the Panel discussions was that when Miss E was recognised as a victim in a number of incidents, a referral was not always made to the Lighthouse Victim and Witness Care service to offer support. This did not provide assurance to the Panel that there was a robust victim support process in place following reported domestic incidents to the police.

14.20 With reference to the Lighthouse Victim and Witness Care Service, this service aims to provide a comprehensive coordination function following police attendance at an incident. The team works closely with other agencies including local specialist domestic abuse support services to refer victims onto for advice and support and another team called the Safeguarding Coordination Unit screen and re-assess for safeguarding actions and referrals to MARAC. It is clear that the lighthouse team did thoroughly research these incidents, however on occasion the follow up actions were not taken. At the time of this case, the Lighthouse team would only follow up actions where there is a crime. Unfortunately, a number of the incidents reported and attended by the police for this case did not equate to a crime and therefore did not fall into the remit of the lighthouse team.

14.21 In the opinion of the IMR Author there was also a missed opportunity to use the neighbourhood beat teams to review and follow up with Mr D and Miss E following repeated domestic abuse calls. It was also highlighted by this author that some additional guidance on domestic abuse screening techniques to avoid colluding with the perpetrator, providing services to someone who doesn't need them and equipping a perpetrator of domestic abuse (who presents as a victim) with information that may be used to further abuse their partner.

14.22 The Panel agreed that there was some good practice shown by a number of officers when attending Miss E's property following a domestic incident because where a DASH was refused by either party, often officers would attempt to complete one afterwards to understand the severity of the risk and issues. This provided assurance that the officers recognised the importance of risk assessing domestic incidents. In addition to this, the Panel also felt that one officer in particular should be commended for their efforts to escalate their concerns on the basis of poor mental health of both parties, drug misuse and regular police attendance at Miss E's address. The officer used their professional judgement which displayed a good understanding that a different intervention or action was needed.

Taunton Association for the Homeless

14.23 This IMR was commissioned because both parties had been known to this organisation. It transpires from the IMR that there was no evidence to suggest that they were in a relationship and knew one another well prior to January 2016 when we know their relationship began. However, in the opinion of the IMR author and Panel this review has been a useful process to the organisation in raising the awareness of domestic abuse as a safeguarding issue of its own.

14.24 By considering what policies, protocols and training are in place to deal with domestic abuse cases for this small, local organisation has highlighted a number of gaps and therefore these opportunities can be taken forward to improve this agency's response to domestic abuse.

Bristol Gloucester Somerset Wiltshire (BGSW) Community Rehabilitation Company

14.25 This IMR has provided the review with a significant amount of background information on Mr D because he was known to this service before his custodial sentence in 2015, which has been extremely valuable. Mr D disclosed long-term issues with depression in 2012 when he first became known to this service and it was highlighted following a thorough analysis that the case management assessment skills for identifying vulnerability and working with service users with long term mental health issues requires significant improvement. This was because his only vulnerability which was recognised and flagged related to his drug use.

14.26 Another theme which has been emphasised in this case was that case managers meeting Mr D on a relatively frequent basis were focussed on his drug misuse and offending and therefore did not take more holistic approach to his situation and wellbeing. The IMR author noted that this organisation is undertaking a programme of work called Skills for Effective Engagement and Development (SEEDs) which aims to develop practitioner's skills and practices in working with offenders more holistically and increase their confidence to be more investigative in their approach.

14.27 This IMR also highlighted to the Panel Mr D's sexuality, following a disclosure of a same sex relationship in 2012 to this organisation. Following the exploration of how Mr D was dealt with by this organisation at this time, the IMR author found that greater work was needed to seek assurance that case managers are more responsive to the needs of LGBT service users. This was because it appeared from the case records that his sexuality and other vulnerabilities were not risk- assessed (given it is a protected characteristic) and therefore there was not an adequate plan to protect and support him sufficiently. Instead contacts Mr D had with this service were more often reactive.

14.28 This IMR did also highlight some good practice whereby this organisation attended a meeting with the prison, Mr D and his parents following Mr D's completion of a programme whilst in prison. Attendance at the meeting enabled the case manager to learn what Mr D had completed during this period so that the same learning could be reinforced following release from prison.

14.29 There was also some discussion by the Panel in relation to Mr D's behaviour (failing drug tests) following his release from prison and what actions were and were not taken by this service. It is acknowledged in the IMR that at various stages a review of the initial sentence plan and his licence conditions should have been undertaken and that case managers should be reminded to comply with Probation Instruction on Recall.

14.30 Another learning point which was raised by the IMR author related to the policies held by this organisation for safeguarding and domestic abuse. Both Miss E and Mr D were known to this service albeit not at the same time during 2016-17, however this review has raised the concern that where case managers become aware of service users forming relationships with others that have violence, mental health or substance

misuse in their profile that safeguarding action should be taken in some form, underpinned by a clear policy and process.

14.31 Finally, a Panel discussion was had in relation to the disconnect between the reported police incidents and this agency because this information was not shared with the case managers. The Panel felt that had this information been shared, given Mr D had to attend regular appointments with this organisation a conversation could have been explored about his relationship. The Panel agreed that a recommendation should be considered to address this issue.

15 There were a number of other themes which were discussed by the Panel as part of this review. These were the following;

15.1.1 Situational Couple Violence

15.1.2 Recognition and support locally for male victims

15.1.3 Shared learning across the whole system for complex cases

15.2 Situational Couple Violence (SCV) was defined by Johnson (2008) as a type of intimate partner violence which is enacted as a means of controlling a specific situation or context and is often a disagreement that escalates into violence, as opposed to being about exerting power and control from one person onto another. SCV is relevant here because there is little evidence from the risk assessments undertaken to suggest that the intimate partner violence/abuse experienced by Mr D or Miss E was about power and control. To the contrary, the evidence suggests it was an unhealthy relationship where abuse occurred in the context of conflict about drug misuse. We understand from the reported incidents to the police that Miss E was perhaps the primary aggressor, however without any understanding of how Mr D felt about many of the reported incidents it is unclear to categorise whether one individual was the victim.

15.3 There have been a number of pieces of research undertaken to understand more about what the difference is between the power and control model of intimate partner violence and SCV, as well as the impact. A study by Leone, Johnson and Cohan (2007) found that those experiencing SCV are more likely to seek help from family and friends informally, in the hope that they can 'fix' the problem which causes the conflict and remain in the relationship. This is fundamentally different to an abusive relationship focussed on a power and control phenomenon where victims seeking help are often looking for an escape route to leave the relationship due to fear of violence, abuse and sometimes death. This is useful to note in this review because without engagement from family members we are unsure whether Mr D sought to find help for this situation and his relationship with Miss E. However, this does highlight the importance of how raising the awareness about how friends and family can support others in situations of intimate partner violence is critical to preventing further harm.

15.4 All organisations who were part of the Panel for this review recognised this theme and many have incorporated this into their recommendations to improve how they can respond to this type of intimate partner violence as Johnson describes.

- 15.5 The next theme which was considered by the Panel related to the awareness of male victims of domestic abuse. This was recognised at numerous points during the Panel discussions for example, where upon attendance at Miss E's address by the police she was identified as a victim on the majority of occasions due to preconceived ideas as opposed to what had been reported by third parties. In addition, the domestic abuse policy created by Taunton and Somerset NHS Foundation Trust also did not acknowledge well enough that men can be victims of domestic abuse too. The Panel understands the statistics for domestic abuse and how it is more prevalent for women to be victims, however this review and the responses given by organisations highlighted a training and awareness gap.
- 15.6 The Chair reminded all organisations to re-consider their policies and training schedules to ensure that the message is clear how males can be victims too. The Panel were assured that support services are available locally for those male victims who do disclose and wish to seek support; this is via Somerset Integrated Domestic Abuse Service (SIDAS). Somerset Integrated Domestic Abuse Service supports individuals experiencing abuse regardless of gender or sexuality. However, ManKind and Men's Advice Line, two national organisations who specialise in supporting male victims of domestic abuse also are known in Somerset and therefore Panel members were aware of these services.
- 15.7 Finally, the last theme which was considered as part of the review related to sharing learning across the system in particular the health system. This was emphasised as a concern when consideration was given to the effective learning required for health professionals, with particular regard to practicing professional curiosity and therefore the importance of where one part of the health system e.g. The acute provider decides to embed this as a recommendation how the community provider and mental health provider should also consider the same. This is so that victims of domestic abuse receive a consistent level of service and response to this safeguarding issue in the same health system.
- 15.8 Following a comprehensive discussion about this concern held by the Panel it was agreed that the governance for embedding consistent learning across the systems in a coordinated fashion was held by the Adults Safeguarding Boards and therefore the Panel was content to support a recommendation which reflected this.

16 Conclusions

- 16.1 In reaching their conclusions the Review Panel have focussed on the following questions;
- Has the Panel fulfilled the Terms of Reference for this review by undertaking a variety of lines of enquiry, including discussing the draft chronology and entering broader more strategic discussions about cross authority working?
 - Will the actions and suggestions for improvement improve the response domestic abuse victims have in the future?

- What are the key themes or learning points from this review?
- 16.2 The Review Panel are satisfied that the Terms of Reference have been fulfilled and that discussions did take place at the Panel meeting to consider what was known prior to Mr D's death in April 2017.
- 16.3 The Panel is of the opinion that the agreed recommendations appropriately address the points raised throughout the review, particularly in relation to the lessons learnt and the themes discussed.
- 16.4 The Panel felt that there were a number of key issues which were fundamental to the discussion and therefore key learning points. Firstly, the fact that Mr D was not regarded as the victim, despite third party reports, did not enable conversations and appropriate risk assessments to be undertaken with him. The Panel also felt that because he was a male there was an assumption made that he was the perpetrator of abuse for the domestic incidents reported to the police, therefore summarising that gender stereotypes were most probably at play during this time.
- 16.5 Another key learning point which the Panel felt was replicated across a number of organisations was that of professional curiosity. It was felt that at most contacts Mr D had with agencies it was surface level conversations about his offending, drug use or clinical needs; not investigative or holistic in seeking further information about the situation and life he was leading. This resulted in the Panel concluding that more awareness raising, and training was required by practitioners on how to engage with individuals with complex needs and ask sensitive questions.
- 16.7 Lastly, despite the complexities which Mr D had; poor mental health, chaotic drug use, involvement in repeated domestic incidents reported to the police, homelessness and his licence conditions from prison there was no coordination of information held by all of the agencies to discuss and agree what additional actions/support could be offered to Mr D. Mr D was a vulnerable individual as a result of these complexities and should all of the information been shared, there may have been a greater chance of one agency being able to engage with him and support him with some positive steps forward. However, he did not fit an obvious multi agency strategy discussion process therefore this would have had to have been a bespoke complex case needs meeting.

17. Recommendations

17.1 Somerset Drug and Alcohol Service

17.1.1 Additional training to be provided to all this agency's staff in relation to identifying Domestic Abuse and Violence and making appropriate referrals.

17.1.2 This agency to ensure risk assessments are reviewed and completed in absence of the service user if they continually fail to engage in treatment and risk management plan to consider and address "past" issues as well as "present".

17.1.3 This agency to consider developing “Crisis, Relapse & Contingency Plans” with details of emergency contacts and useful advice to use in the event of serious distress. This has now been implemented and is operational.

17.2 Somerset Partnership NHS Foundation Trust

17.2.1 Information volunteered re relationship difficulties should stimulate further questioning / “professional curiosity” by staff involved to gain fuller understanding of what client is experiencing at that time. This could be fulfilled by emphasising the importance in safeguarding adults training and the Trust’s newsletter as a reminder.

17.2.2 Risk screen and information to be completed in relation to all MHA assessments to include recording current suicide risk. This would be achieved by monitoring this practice through supervision and caseload management.

17.3 Somerset Clinical Commissioning Group

17.3.1 This agency, with the support of the Chair, to seek further guidance and clarity to be sought from the Home Office in relation to sharing information about an ‘alleged perpetrator’ following a suicide.

17.4 Taunton and Somerset NHS Foundation Trust

17.4.1 In all cases of assault that attend the Emergency Department, the nature of the assault should be documented, and the victim should be asked who the perpetrator of the assault was. This should be clearly documented. If domestic abuse is identified staff should act in line with Trust policy.

17.4.2 This agency to continue with plans to employ a Homeless Health Support Worker for the Trust to assist with co-ordinating multi-agency intervention (including where domestic abuse identified) when required following attending the Emergency Department.

17.4.3 Review if improvements can be made to the Emergency Department’s response to domestic abuse e.g. Routine enquiry.

17.4.4 This agency to share the overall findings of the DHR with Emergency Department Staff

17.4.5 This agency to add a new powerpoint slide to the Emergency department training presentation outlining the issues raised by this case.

17.4.6 Learning from this review report to be shared with the Trust Safeguarding Committee and a summary of the key issues are shared with all staff through the Staff Bulletin.

17.4.7 All referrals to the Safeguarding team to be consider for flagging on the MAXIMS system. Flags to be added for medium risk cases (alongside current high-risk flagging) and to use professional judgment when considering flagging other cases.

17.4.8 This agency to change wording on front page of Domestic Abuse policy from 'Women should be regularly asked if they are experiencing domestic abuse' to 'Ask any individuals whose attendance could be related to Domestic Abuse (such as assaults of physical injuries) if they are a victim of Domestic Abuse and to use more consistent terminology in the policy; using the term Domestic Abuse rather than Domestic Violence

17.5 Avon and Somerset Constabulary

17.5.1 'Situational couple violence' recognised as an issue and to be added to the current DA procedural guidance, to include information on screening techniques. In addition, this guidance will need to be disseminated through training

17.5.2 This agency to ensure that there is a process in place across the force where repeated DA reporting (including reports by third parties) are tasked for review and followed up by Neighbourhood Beat teams.

17.6 Taunton Association for the Homeless

17.6.1 This agency to revise their safeguarding policy ensuring that domestic abuse is covered in detail with regards to spotting the signs of abuse, and steps that can be taken to help safeguard a victim from harm.

17.6.2 This agency to forge closer links with the domestic abuse specialist service in Taunton; Somerset Integrated Domestic Abuse Support Service to ensure that staff feel confident in signposting and making referrals to this agency.

17.7 BGSW Community Rehabilitation Company

17.7.1 BGSW CRC case managers to receive training in order to identify and take appropriate actions when there is potential domestic abuse in cases they manage.

17.7.2 This agency to ensure that staff demonstrate they clearly understand and adhere to BGSW CRCs approach to managing potential domestic abuse

17.7.3 Staff to clearly understand and adhere to BGSW CRCs approach to safeguarding

17.7.4 Case managers to develop an investigative approach when working with service users. With a particular emphasis on identifying potential domestic abuse, safeguarding, vulnerability and protected characteristics.

17.7.5 Case managers to develop effective information gathering/sharing practice with police and other key partner agencies.

17.8 Somerset Integrated Domestic Abuse Service

17.8.1 To promote their services to all individuals who maybe experiencing abuse regardless of gender or sexuality.

17.9 Additional Panel recommendations

17.9.1 Somerset Safeguarding Adult Board to lead on sharing learning from DHR19 in relation to professional curiosity across health economy in Somerset and gain assurance that this learning is embedded across all NHS Trusts and change is implemented.

17.9.2 All Panel members to raise awareness of male victims of domestic abuse amongst their organisation.

17.9.3 Police and BGSW CRC to consider how they could improve communication channels where an individual is on licence and repeated involved in domestic incidents or similar.

17.9.4 Home Office to consider mandating housing associations to become part of DHR Panels where they have had some involvement in order to improve awareness and responses for domestic abuse victims.

18. Postscript

18.1 Actions to be taken after presentation of the Overview Report to the Safer Somerset Partnership

18.2 The partnership should:

- Agree and sign off the content of the Overview Report for publication, ensuring that they are fully anonymised, apart from the names of the Review Panel Chair and members.
- Provide a copy of the Overview Report and supporting documents to the Home Office Quality Assurance Group. This should be via email to DHRENQUIRIES@homeoffice.gsi.gov.uk
- The document should not be published until the partnership has received confirmation from the Home Office that the report has passed the QA process.

18.3 On receiving clearance from the Home Office Quality Assurance Group, the Safer Somerset Partnership should:

- Provide a copy of the Overview Report and supporting documents to the senior manager of each participating agency.

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- Decide whether an electronic copy of the Overview Report (this must be carefully redacted) and Executive summary should be published on the Safer Somerset Partnership website
- Monitor the implementation of the specific, measurable, achievable, realistic and timely (SMART) Action Plan.
- Formally conclude the review when the Action Plan has been implemented and consider an audit process
- Make arrangements to provide feedback and debriefing to staff, family members and the media as appropriate.

Appendix A

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Pieces of legislation

Adoption and Children Act 2002

Crime and Disorder Act 1998

Domestic Violence, Crime and Victims Act 2004

Equalities Act 2010

Serious Crime Act 2015

Care Act 2014

Protection from Harassment Act 2002

Appendix B

Confidentiality Statement



Somerset Domestic Homicide Review into the Death of
Mr D

CONFIDENTIALITY AGREEMENT

– PLEASE READ THIS DOCUMENT CAREFULLY

This document must be read and signed by all members of the DHR Panel.

If you have any questions concerning this document, please contact your manager before signing. You should retain your own-signed copy for future reference.

Many of the services that agencies in the Somerset area provide for its clients are confidential and to enable them to perform these services, its clients disclose confidential and personal information to those involved in their care and assistance.

The goodwill and respect of these agencies depends amongst other things upon keeping such services and information confidential. You may have access to such information, see or hear information of a confidential nature during your involvement in the DHR Panel.

You are not permitted at any time during or after your involvement in the DHR Panel to disclose any such personal or business information whatsoever including to colleagues and line managers. In holding information you occupy a position of trust which you are required to respect. Any breach of confidentiality will be viewed seriously and could result in termination of your contract.

You will need to observe the very basic rule that information revealed and Panel discussions are confidential. It should not be discussed with anyone except when written permission has been sought from and granted by the Chair. In no circumstances should you discuss it with family, friends, other clients, the general public or in any public place. In addition you are not permitted to or allow any unauthorised person/s to examine or to make copies of any reports documents or business information to do with clients or the business of this DHR. Any information you hold should be deleted or handed back to the Chair at the end of the Review. Disclosure may be in breach of the Data Protection Act and may give rise to irreparable injury to the clients as the owner of such information; and they may seek remedy against the agency where you employed.

If you are in any doubt about the disclosure of any information **you should consult the Chair.**

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I confirm that I have read and understand the above. I understand that any breach of this confidentiality will be regarded as a serious matter by the Chair and Somerset CSP and may result in legal proceedings.

NAME:

SIGNATURE:

AGENCY:

DATE:

Appendix C- Action Plan

See Separate Document

Appendix D

List of agencies approached about this Domestic Homicide/Suicide Review

Somerset

Avon and Somerset Constabulary
Bournemouth Churches Housing Association
Education (Somerset County Council)
Knightstone (Somerset Integrated Domestic Abuse Service)
Probation (National Probation Service and BGSW Community Rehabilitation Company)
Sedgemoor District Council
Somerset and Avon Rape and Sexual Abuse Support (SARSAS)
Somerset Clinical Commissioning Group
Somerset County Council (Adults and Children Social Care)
Somerset Partnership NHS Foundation Trust
South Somerset District Council
South West Ambulance Trust
Taunton and Somerset NHS Foundation Trust
Taunton Deane Borough Council
Turning Point (Somerset Drug and Alcohol Service)
West Somerset District Council
Victim Support
Yeovil Hospital NHS Foundation Trust

Appendix E – Glossary

Coercive Control	A pattern of behaviour which seeks to take away the victim's liberty or freedom, to strip away their sense of self
DASH	Domestic Abuse Stalking and Honour Based Violence (<i>Risk Indicator Checklist</i>)
Domestic Homicide Review	A review to establish lessons that can be learnt from domestic homicides to improve responses to domestic abuse.
GP	General Practitioner
IMR (Individual Management Review)	A scrutiny review undertaken internally within an agency about the involvement of the agency with the subjects of the review.
MARAC (Multi Agency Risk Assessment Conference)	A meeting/process which enables information to be shared about high risk victims of domestic abuse with other key agencies.
Pseudonym	A fictitious name used by an author.
Senior Investigating Officer	The police officer leading the investigation
TAH	Taunton Association for the Homeless